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STACKS

STACKS

Special issue on domestic violence

*A special message from the
AMA president*

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*Finding the right words —
advice on talking to victims*

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*Why victims stay in
abusive relationships —
the dynamics of
power and control*

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Who are the batterers?

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*The effects of domestic
abuse on children*

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*Test your knowledge of
domestic abuse issues
(survey of Iowa
physicians)*

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Late-breaking news of interest to Iowa physicians

●**AN ARTICLE IN THE DECEMBER IOWA MEDICINE** Medical Economics section stated an incorrect amount of total Medicare benefit payments coming into Iowa during 1993. During fiscal year 1993, \$1.3 billion was paid for 469,081 Iowa Medicare enrollees. For the same period, the state of Colorado collected \$1.42 billion in benefits for 396,453 enrollees. For a complete state-by-state listing, call Donna Bottorff at the IMS, 800/747-3070.

●**ESTABLISHMENT OF A STATEWIDE TRAUMA SYSTEM** will be supported by the Iowa Medical Society in this year's Iowa Legislature (see page 14 of this *Iowa Medicine*). Any physician who wants more information about the statewide system proposed by the Iowa Trauma Systems Development Project Planning Consortium is urged to call Thomas Foley, MD, 515/752-6391 or Tim Peterson, MD, 515/224-6440. For copies of the Consortium report, call Dick Harmon, Iowa Department of Public Health, 515/281-3741.

●**THE 11th ANNUAL INTERNATIONAL SYMPOSIUM ON CREATION OF** Electronic Health Record Systems and Global Conference on Patient Cards will be held March 14-19 at the Disney Contemporary Resort in Orlando, Florida. For more information on the conference, call Donna Bottorff of the IMS staff, 800/747-3070.

●**DON'T MISS THE IOWA TELEMEDICINE CONFERENCE** "The Future is Now" Monday evening, January 9 from 7:00 p.m. to 9:30 p.m. The program is designed for physicians, nurses and others. Cosponsored by the IMS, U of I College of Medicine and others, the program will cover what telemedicine can do for providers, how much equipment will cost and reimbursement issues. The program can be seen at 54 different sites around Iowa. For information about the site in your area, call Lyn Durante at the IMS, 800/747-3070.

●**THE IMS ELECTION PROCESS** is beginning with district caucuses to be held around the state this month and in February. At each caucus, physicians will choose a representative and an alternate to the 1995 Nominating Committee. This committee will hold a telephone conference March 12 to compile a slate of candidates. The caucus schedule can be found on page 12 of this issue.

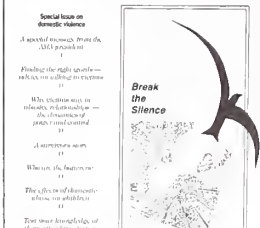
●**THE IOWA INSURANCE DIVISION** is delaying implementation of administrative rules concerning employee health care access under Senate File 2282 passed by the legislature last year. The new rules – which are being revised to clarify confusion as to the exact requirements for employers – probably won't go into effect until some time in late February.

●**TO GET A COPY OF THE FEDERAL REGISTER** which contains information regarding Iowa's designation as a single Medicare payment locality with one fee schedule, updated RBRVS and 1995 Medicare payment policies: (credit card order) 202/512-1800; (fax order) 202/512-2250; or write to: New Orders, Superintendent of Documents, PO Box 371954, Pittsburgh, PA 15250. The price is \$8, stock number 069-001-000-81-5.

●**THE AMA EXPRESSED CONCERNS ABOUT PROPOSED MEDICARE CUTS** in a letter from James Todd, MD, AMA executive vice president, to President Clinton. According to the letter, Medicare reimbursement of physicians accounts for only 23% of Medicare expenditures, yet physicians have been subjected to 40% of provider cuts. The AMA is proposing examination of premium levels and deductibles and an income related sliding scale for beneficiary cost sharing.

Iowa Medicine

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EDITORIALS

7 Watch for red flags

Every Iowa physician should be on the lookout for signs of domestic violence in their patients.

● THE PRESIDENT COMMENTS

9 Give the gift of hope

The American Medical Association president has a message for Iowa physicians regarding ethical responsibilities and domestic violence.

● ROBERT McAFEE, MD

11 A mass media reality check

Should the media accept a share of responsibility for the explosion of violence in America? The IMS Alliance president says yes.

● BARBARA BELL, IMSA PRESIDENT

About the Cover

It is estimated between 20,000 and 44,000 Iowa women are battered by their intimate partners each year. This issue and the February issue of Iowa Medicine are devoted to educating physicians on how to help victims. The logo on the cover was designed by IMS Alliance President Barbara Bell.

Iowa Medicine, Journal of the Iowa Medical Society (ISSN 0746-8709), is published monthly by the Iowa Medical Society. Subscription price: \$25 per year. Second class postage paid at Des Moines, Iowa and at additional mailing offices. POSTMASTER: Send address changes to Iowa Medicine, Journal of the Iowa Medical Society, 1001 Grand Avenue, West Des Moines, Iowa 50265. NATIONAL ADVERTISING: State Medical Publishers Network, 9534 Marshall Drive, Shawnee Mission, KS 66215, phone 913/888-8781. IOWA ADVERTISING: Jane Nieland, Iowa Medicine, 1001 Grand Avenue, West Des Moines, Iowa 50265. Phone 515/223-1401. EDITORIAL CONTENT: The Society is unable to assume responsibility for the accuracy of that which is submitted. Manuscripts or editorial inquiries should be directed to the Editor, Iowa Medicine, 1001 Grand Avenue, West Des Moines, Iowa 50265. Copyright 1995 Iowa Medical Society.

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Break the silence, begin the cure

Seventy-five percent of partner battering victims seek treatment for immediate or long-term effects of abuse. However, these victims are hardly ever identified. The articles on the following pages are designed to give Iowa physicians information they can use in their practices.

Finding the right words

Experts in partner battering offer excellent advice on how to talk to victims.

Why do they stay?

Victims of domestic violence often take years to leave the abusive relationship. A counselor discusses the insidious dynamics of power and control. ● *KAY MAHER-SHARP*

A survivor's story

During her 12-year marriage, she was degraded, stalked and nearly beaten to death. Now she's putting her life back together. ● *CHRISTINE CLARK*

Who are the batterers?

A counselor with the Polk County Domestic Abuse Intervention Service discusses common characteristics of abusers. ● *DALE CHIELL*

Test your knowledge of domestic violence issues . . .

Don't miss the survey of Iowa physicians in the center of this *Iowa Medicine*

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A child's perspective

The author discusses the effects of domestic violence on children. ● *DONNER DEWDNEY, MD*

Understanding domestic violence

Behavioral "repertoires" common to batterers. ● *TRUCE ORDONA, MD*

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The AMA in action

Managed care and other issues received attention at the AMA's Interim Meeting in December.

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North Iowa responds to domestic violence

A member of the IMS Alliance discusses a local community approach to the problem of domestic violence.

● **MAXINE BRINKMAN, RN**

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- New members, awards, obituaries

Iowa Medicine

[illegible]

**No one deserves
to be hurt.**

About the Cover

This is the second of two issues devoted to domestic violence. The poem on the cover was written for the Clothesline Project of the Polk County Family Violence Center.

Iowa Medicine, Journal of the Iowa Medical Society (ISSN 0746-8709), is published monthly by the Iowa Medical Society. Subscription price: \$25 per year. Second class postage paid at Des Moines, Iowa and at additional mailing offices. POSTMASTER: Send address changes to *Iowa Medicine*, Journal of the Iowa Medical Society, 1001 Grand Avenue, West Des Moines, Iowa 50265. NATIONAL ADVERTISING: State Medical Publishers Network, 9534 Marshall Drive, Shawnee Mission, KS 66215, phone 913/888-8781. IOWA ADVERTISING: Jane Nicland, *Iowa Medicine*, 1001 Grand Avenue, West Des Moines, Iowa 50265. Phone 515/223-1401. EDITORIAL CONTENT: The Society is unable to assume responsibility for the accuracy of that which is submitted. Manuscripts or editorial inquiries should be directed to the Editor, *Iowa Medicine*, 1001 Grand Avenue, West Des Moines, Iowa 50265. Copyright 1995 Iowa Medical Society.

Late-breaking news of interest to Iowa physicians

●**THE IMS CHMIS COMMITTEE** is recommending adoption by the IMS House of Delegates of a "statement of principles" to guide IMS participation in development of the Iowa Community Health Management Information System. These principles will ensure that physician interests – including concerns about confidentiality and ethics – are fairly represented. For more details about the recent meeting of the IMS CHMIS Committee, see the March **Medical Economics** section in *Iowa Medicine*.

●**AN ANALYSIS OF THE REPUBLICAN "CONTRACT WITH AMERICA"** in the context of AMA policy is available by calling Chris Clark at IMS headquarters, 515/223-1401 or 800/747-3070.

●**FOR THE LATEST ON THE GEOGRAPHIC PRACTICE COST INDICES** (GPCIs) for Iowa physicians, turn to this month's Futures section on page 60. You will also find information on the 1995 Medicare Conversion Factor published in a recent *Federal Register*.

●**SOME OF YOU WHO ATTENDED THE IMS FUTURES CONFERENCE** last October expressed an interest in a book on capitation written by Bill DeMarco, one of the conference speakers. According to DeMarco, the book is in the final editing stage and will be completed in about a month.

●**THE PRICE OF PHYSICIAN SERVICES AS MEASURED BY THE** Consumer Price Index increased 4.4% during the 12 months from December, 1993-December, 1994. This was the lowest December-to-December change since 1973.

●**IOWA MEDICAL SOCIETY LEADERSHIP** has approved a blueprint for specialty society representation in the IMS House of Delegates. The blueprint and amended bylaws will be submitted to the IMS House of Delegates in April. If adopted, specialty societies who meet the criteria will be eligible to participate in the 1996 IMS House of Delegates.

●**A STATE DATA CONFERENCE** is planned for Thursday, April 6 in Des Moines. The purpose of the conference is to explore options and develop a state health data strategy. CME credit will be available. For more information, call Barb Heck at the IMS, 800/747-3070.

●**PHYSICIANS ARE ADVISED THAT SOME IOWA NEWSPAPERS** have unknowingly published a press release which attempts to charge consumers \$9.95 for government booklets on Medicare which can actually be obtained for free. The press release, entitled "New Medicare Publications Now Available", advertises the **Medicare 1994 Handbook** and the **Guide to Health Insurance**. These publications and others may be obtained FREE by writing to: Medicare Publications, Health Care Financing Administration, 6325 Security Boulevard, Baltimore, Maryland, 21207. For a list of free Medicare publications available for consumers, call Chris Clark at the IMS, 800/747-3070 or 515/223-1401.

●**A 3-DAY SEMINAR ON SPECIALTY CODING** by nationally-known coding expert Nancy McGuire will be sponsored by the Iowa Medical Society Tuesday-Thursday, April 18-20, in Des Moines. The seminar will cover coding for primary care, neurosurgery, orthopedic surgery, ENT, pediatrics and others. You will receive a mailing on this special seminar.

●**MEDICARE PHYSICIAN PARTICIPATION RATES FOR 1995** should be available by mid-February when the 1995 MEDPARD book is released. The MEDPARD is mailed to all participating physicians. For more information, call Barb Heck at the IMS, 515/223-1401 or 800/747-3070.

FEATURE ARTICLES

70 Domestic violence: the law and physician liabilities

A Des Moines attorney discusses physician reporting responsibilities under Iowa law and commonly asked questions regarding patient consent and legal protections.

● JEANINE FREEMAN, JD

Documenting domestic abuse

An Iowa police officer gives advice on medical record and photographic documentation of domestic abuse. ● CURTIS RUBY

Rural battered women

Limited access to a telephone, a means of transportation and the court system are some of the special problems faced by battered women in rural Iowa. ● LAURIE SCHIPPER

Domestic violence programs across Iowa

A map and other referral information for physicians across the state.

What works, what doesn't work

Iowa physicians offer advice on how to deal with victims in your office.

An insert
for your
patients . . .
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Medicine*.
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Nieland at
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85 Iowa domestic abuse scenarios

What choice would you make in these situations?

● LEE FAGRE, MD; KATHLEEN BUCKWALTER, RN

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● WARREN BOWER, MD; DAVID COSTER, MD; MARK WESTBERG, MD; VICTOR WILSON, MD

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Iowa Medicine

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Exciting times

Communities all over Iowa are pursuing dramatically different ways of providing health care. ● *THE PRESIDENT COMMENTS*

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King Will and the Foul Humours

Don't miss this wonderfully satirical Fable for Health System Reform which brought down the House of Delegates at the AMA's Interim Meeting in December. ● *ROBERT McAFEE, MD, PRESIDENT, AMA*

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About the Cover

Lois Stoltze, MD, an anesthesiologist at McFarland Clinic in Ames, checks on a patient before surgery.



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IMS DEADLINE news

MARCH, 1995

Late-breaking news of interest to Iowa physicians

•**VIDEOTAPES OF THE JANUARY TELEMEDICINE CONFERENCE** cosponsored by the Iowa Medical Society are now available. Two different videotapes are available – one of the entire program and one depicting a fiberoptics consult between physicians in Des Moines and Fort Dodge. Call Becky Roorda or Lyn Durante at the IMS, 515/223-1401 or 800/747-3070.

•**THE IOWA MEDICAL SOCIETY WAS MENTIONED IN A RECENT** *Des Moines Register* article on possible reinstatement of the death penalty in Iowa. IMS President James White, MD commented on IMS and AMA ethical policy which forbids physician participation in state executions. For a complete explanation of IMS/AMA policy on capital punishment, see the April *Iowa Medicine*.

•**APPARENTLY, THERE'S TROUBLE IN MINNESOTA** as Minnesota House and Senate Republicans have announced a plan to dismantle several aspects of the much-touted health care reform plan, MinnesotaCare, including the 1997 deadline for achieving universal coverage and community rating. Iowa physicians were recently part of a successful lawsuit against the state of Minnesota over a 2% provider tax assessed against out-of-state physicians treating Minnesotans. A judge ruled the tax unconstitutional for out-of-state providers; the state of Minnesota has decided not to appeal.

•**A RECENT WALL STREET JOURNAL ARTICLE** described the AMA's new Physician Capital Source Program, which Iowa physicians learned about during last October's Futures program in Des Moines. The *Journal* said the AMA's project "will give doctors business skills and introduce them to sources of capital so they can compete against insurers and investor-owned HMOs dominating the health care landscape". For more information about the program, call the AMA Managed Care Hotline, 800/AMA-1066.

•**THE IOWA FOUNDATION FOR MEDICAL CARE** is beginning a new project which will involve 100 Iowa physicians. The Ambulatory Care Quality Improvement Project is a multi-Peer Review Organization pilot cooperative project which will focus on improving care in physician offices for Medicare patients with diabetes mellitus. The project will promote physician self-examination. IFMC is sending letters to a randomly-selected group of physicians requesting their participation. You may volunteer for this project by calling Peg Mason at IFMC, 800/383-2856.

•**THE IMS/IOWA STATE BAR ASSOCIATION REGIONAL MEETINGS** will be held Tuesday, March 14 in Des Moines; Tuesday, March 21 in Sioux City and Monday, March 27 in Cedar Rapids. The program will focus on end-of-life/futile care and sexual harassment in the health care workplace. For more information on attending, call Tina Preftakes at the IMS, 800/747-3070.

•**SF 84, INDIVIDUAL INSURANCE REFORM**, has passed both the Iowa House and Senate and is on its way to the Governor for signature. Key provisions include: limiting rate variations for blocks of business and prohibiting use of rating characteristics other than age, geographic area and family composition; disclosure required to prospective customers of provisions related to preexisting conditions; renewal of policies is required unless premiums have not been paid or the company discontinues business; coverage must be made available to eligible individuals within 30 days of another policy being discontinued; restrictions on coverage for preexisting conditions may not be for more than 12 months. Standards for plans will be set by the insurance commissioner.

For more information about any **DEADLINE news** item, call Chris Clark at
IMS headquarters, 515/223-1401 or 800/747-3070.

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Pitfalls of integration

The decision to integrate should be made only after a thorough analysis of what the physician has to gain and the potential risks.

● ROBERT KRYPEL, JD

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Antibiotic resistance: an emergency we can't ignore

As bacteria adapt to their changing environment, the effects of antibiotic resistance will be increasingly felt by Iowa physicians and their patients. ● STEPHEN RINDERKNECHT, DO

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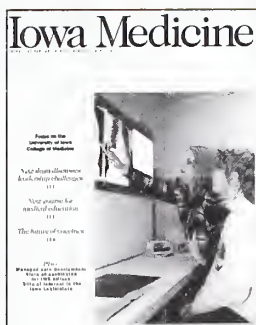
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About the Cover

Joan Harding, MD, a family practice physician in Marengo, explains a chest x-ray to patient Dawn Weldon. Using a computer and a telephone, the hospital is able to transmit x-rays to the UI Department of Radiology. Photo by David Pedersen.

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Helping our patients and communities

The IMS Education Fund helps physicians and the public and would not exist without your generosity. ● *THE PRESIDENT COMMENTS*

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UI College of Medicine in the 21st century

The new dean of the UI College of Medicine discusses his vision for the future and the leadership challenges he faces.

● *ROBERT KELCH, MD*

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Late-breaking news of interest to Iowa physicians

●**THE IMS BILL ON STATUTE OF LIMITATIONS** has passed the Iowa House, but its fate in the Senate is uncertain. **Physicians should contact their Senators immediately and ask them to support HF 394!** The bill passed the House on Monday, March 27 on a vote of 71 - 24. The bill would reduce the statute of limitations for minors so the normal two-year statute would begin at age 6. In effect, this means a lawsuit for an alleged birth or early childhood injury would need to be filed by the child's eighth birthday. Ninety-seven percent of lawsuits for birth injuries are brought within this time period; the bill would encourage the remainder to be filed earlier when witnesses are still available, memories are clearer and the standard of care prevailing at the time clearly established.

Representatives who voted for the IMS bill to reduce the statute of limitations are:

Democrats - Baker, Mascher, Bell, May, Drees, Mertz, Mundie, O'Brien, Running, Weigel;
Republicans - Arnold, Blodgett, Boddicker, Boggess, Bradley, Branstad, Brauns, Brunkhorst, Carroll, Churchill, Coon, Corbett, Cormack, Cornelius, Daggett, Disney, Drake, Eddie, Ertl, Garman, Gipp, Greig, Greiner, Gries, Grubbs, Grundberg, Hahn, Halvorson, Hammitt, Hanson, Harrison, Heaton, Houser, Huseman, Jacobs, Klemme, Kremer, Lamberti, Larson, Lord, Main, Martin, Metcalf, Meyer, Millage, Nelson B, Nutt, Rants, Renken, Salton, Schulte, Siegrist, Sukup, Teig, Tyrrell, Van Fossen, Vande Hoef, Veenstra, Weidman, Welter, Van Maanen.

(Please remember to thank your representatives who voted for the bill)

Representatives who voted against the IMS bill to reduce the statute of limitations are:

Democrats - Bernau, Burnett, Cataldo, Cohoon, Connors, Doderer, Harper, Holveck, Jochum, Koenigs, Kreiman, Larkin, McCoy, Moreland, Murphy, Myers, Nelson L, Ollie, Schrader, Shoultz, Warnstadt, Wise, Witt; **Republicans** - Hurley.

●**ALSO IN THE IOWA LEGISLATURE**, SF 449, initiated by the Iowa Chiropractic Society, which would have prevented managed care plans from using physician gatekeepers for chiropractic and podiatric services, failed to emerge from the Senate Human Resources Committee. However, it could appear as an amendment to another bill. SF 339, introduced by the Iowa Optometric Society, would require all managed care plans to reimburse any optometrist if such services are covered by the plan. The IMS asks that you call or write your senator and representative and ask them to oppose all any willing provider bills. These bills make it impossible for physicians in managed care arrangements such as an IPA or PHO to control costs and pick partners.

●**MEANWHILE, THE AMA IS CELEBRATING A BIG VICTORY** following a major victory on the liability reform front. After intense AMA physician lobbying, the Republican-controlled House voted to limit pain and suffering damages in medical malpractice cases to \$250,000. The medical liability amendment is part of a broader product liability bill. According to the AMA, every lawmaker was contacted.

●**IF YOU HAVEN'T READ YOUR MARCH MEDICARE INFO** describing Medicare's April 1 Part B computer conversion, the IMS advises you to do so immediately! There will be a noticeable disruption in cash flow during the conversion. Around March 25, providers should have received three times their normal payment. From April 4 - April 16, claims will be paid daily. However, on April 17, the "hold file" requirement will be reinstated, meaning normal cash flow is not expected again until mid-May. If you have questions, please call Barb Heck or Mary Reinsmoen of the IMS staff.

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● *VERA DORDICK*

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Spring Meeting



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April 21-22, 1995

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Jon A. vanHeerden, M.D.
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Topics

"Management of Metastatic Liver Disease"

"Role of Axillary Dissection in Early Breast Cancer"

"Diagnosis and Treatment of Primary Hyperparathyroidism"

"Evaluation of Thyroid Nodules"

"Current Evaluation and Treatment of Acute Pancreatitis"

"Timing of Surgery in Gallstone Pancreatitis"

"Diagnosis and Management of Post-Cholecystectomy Injuries"

"In Situ Breast Cancer—the Role of Radiotherapy"

"Hypocortisolism—What the Surgeon Should Know"

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Farewell advice

In his final column as IMS president, Dr. White emphasizes the need for Iowa physicians to stay informed and stay involved.

● THE PRESIDENT COMMENTS

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Key bills to Iowa Legislature: AMA scores liability victory in Congress

Expert advice on financing physician managed care ventures

Hospital & reinsurance in new analysis

About the Cover

Greg Paulson, MD, an internist with Medical Associates in Dubuque, visits with Howard Martensen on the skilled nursing unit at Mercy Health Center, Dubuque. Photo by James Shaffer courtesy of Mercy Health Center.

Iowa Medicine, Journal of the Iowa Medical Society (ISSN 0746-8709), is published monthly by the Iowa Medical Society. Subscription price: \$25 per year. Second class postage paid at Des Moines, Iowa and at additional mailing offices. POSTMASTER: Send address changes to *Iowa Medicine*, Journal of the Iowa Medical Society, 1001 Grand Avenue, West Des Moines, Iowa 50265. NATIONAL ADVERTISING: State Medical Publishers Network, 9534 Marshall Drive, Shawnee Mission, Kansas, 66215-1354, phone 913/888-8781. IOWA ADVERTISING: Jane Nieland, *Iowa Medicine*, 1001 Grand Avenue, West Des Moines, Iowa 50265. Phone 515/223-1401. EDITORIAL CONTENT: The Society is unable to assume responsibility for the accuracy of that which is submitted. Manuscripts or editorial inquiries should be directed to the Editor, *Iowa Medicine*, 1001 Grand Avenue, West Des Moines, Iowa 50265. Copyright 1995 Iowa Medical Society.

Late-breaking news of interest to Iowa physicians

●**THE IMS AND IOWA HOSPITAL ASSOCIATION HAVE BEEN WORKING** with representatives of Heritage National Healthplan, Blue Cross Blue Shield and Principal Health Care on a cooperative agreement regarding the AMA's Patient Protection Act. Under the cooperative agreement, the participating organizations would agree to the principles in the Patient Protection Act which protect patients and physicians under managed care. A draft of the agreement has been prepared and is under consideration by the various entities. The final agreement will be published in a future issue of *Iowa Medicine*.

●**THE IMS HEADQUARTERS OFFICE** now has phone mail. The new system allows physicians to call in before and after hours and leave a message with the automated attendant recording. Callers will need a touchtone telephone to use the directory system. Callers will also have a choice of leaving a message with a staff member by dialing his or her extension. The automated attendant recording offers an option at the end for the caller to press 1 and enter the last name of the person they are trying to reach (if you don't know the staff person's extension number). A directory of IMS staff extension numbers will appear in the June *Iowa Medicine*.

●**DR. JAMES TODD, EXECUTIVE VICE PRESIDENT OF THE AMA** since 1990, announced in April that he will retire as AMA EVP at the end of his current contract in June of 1996. He announced his decision at this time to allow the Board of Trustees ample time to carry out an orderly search process and transition. Dr. Todd said he made his decision because a major portion of the agenda he set for himself has been accomplished, including "a change in the style of interaction the organization brings to its external relationships and to leave the AMA well-positioned for the future".

●**THE IMS SERVICES CODING EXTRAVAGANZA** has been rescheduled for June 13 and 14 at the Best Western Des Moines International, Des Moines. See the insert to this *Iowa Medicine* for additional details.

●**1,100 PHYSICIANS AND MEDICAL SOCIETY EXECUTIVES** attended the AMA Leadership Conference in Washington, DC. The Iowa delegation met with four representatives and both Iowa senators. At this time, all of the Iowa congressmen appear to be opposed to future Medicare cuts and are concerned about what they could mean to Iowa's elderly. There is a consensus that very little will be done in the area of health system reform this year.

●**A "DIRECT ACCESS TO CHIROPRACTORS"** amendment was filed from the floor to SF 484, the administration appropriations bill. The amendment would prohibit a managed care plan from using an MD or DO as a gatekeeper for a chiropractor. It passed the Senate April 24; its fate in the House was uncertain as of press time.

●**THE DEPARTMENT OF HUMAN SERVICES** plans to implement managed care for Title XIX substance abuse cases on September 1, 1995. The state has asked for bids from contractors.

●**BEGINNING OCTOBER 1**, there will be new certification of medical necessity forms which physicians are required to sign for Durable Medical Equipment. CIGNA staff believe the new forms will streamline the process, though DME suppliers have launched an aggressive campaign against the new forms. For more information, call Barb Heck at the IMS.

FEATURE ARTICLE

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Financing of physician ventures

Physicians often face major obstacles in securing appropriate financing for managed care ventures. The author discusses how to obtain financing and what it takes to be successful. Information on the AMA's new Capital Source Program can be found on page 206.

● *STEVE DeNELSKY*

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● *GEORGE BERGUS, MD; STEVEN MEIS, MD*

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Why we need to organize

Joseph Hall, MD, 1995-96 IMS president, has some valuable advice in his inaugural column. ● *THE PRESIDENT COMMENTS*

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About the Cover

Pictured on this month's cover is Dr. Joseph Hall, 1995-96 IMS president. Dr. Hall, a Des Moines radiologist, took office April 30. Photo by Bob Willits, corporate photographer for Iowa Methodist Medical Center in Des Moines.

Iowa Medicine, Journal of the Iowa Medical Society (ISSN 0746-8709), is published monthly by the Iowa Medical Society. Subscription price: \$25 per year. Second class postage paid at Des Moines, Iowa and at additional mailing offices. POSTMASTER: Send address changes to *Iowa Medicine*, Journal of the Iowa Medical Society, 1001 Grand Avenue, West Des Moines, Iowa 50265. NATIONAL ADVERTISING: State Medical Publishers Network, 9534 Marshall Drive, Shawnee Mission, Kansas, 66215-1354, phone 913/888-8781. IOWA ADVERTISING: Jane Nieland, *Iowa Medicine*, 1001 Grand Avenue, West Des Moines, Iowa 50265. Phone 515/223-1401. EDITORIAL CONTENT: The Society is unable to assume responsibility for the accuracy of that which is submitted. Manuscripts or editorial inquiries should be directed to the Editor, *Iowa Medicine*, 1001 Grand Avenue, West Des Moines, Iowa 50265. Copyright 1995 Iowa Medical Society.

Late-breaking news of interest to Iowa physicians

●**THE PROCESS OF CREATING A CHMIS FOR IOWA** will continue uninterrupted due to Hartford Foundation approval of CHMIS funding for another year. The funding was crucial since the Iowa Legislature approved a CHMIS but did not provide funding. The grant will carry the process through the target implementation date of July 1, 1996. (Look inside this issue of *Iowa Medicine* for the text of Iowa Medical Society policy on CHMIS recently approved by the IMS House of Delegates.)

●**AN IOWA MEDICAL SOCIETY VIDEO ON PARTNER BATTERING** is complete and available for loan to any IMS member physician. The 27-minute video features Iowa experts on domestic abuse and would be ideal for a county medical society or hospital medical staff program. For more information, call Chris McMahon at the IMS, 800/747-3070.

●**TWO IOWA HOSPITAL GROUPS** plan to merge, according to a recent report in the *Des Moines Register*. Allen Health Systems, which includes Allen Memorial Hospital in Waterloo, will merge with Iowa Health System. Iowa Health System includes Iowa Methodist Medical Center, Iowa Lutheran Hospital, both in Des Moines, and St. Luke's Hospital in Cedar Rapids.

●**AS OF PRESS TIME, THE DEADLY EBOLA VIRUS** continued to spread in Zaire, chiefly affecting health care workers. There have been 170 deaths. Despite the public's concern over the virus, however, scientists and physicians are more concerned about everyday American bugs that have learned to defy modern medicine. An alarming number of familiar bacteria have mutated into new, highly infectious strains.

●**AN EFFORT TO TURN BACK COUNTY-WIDE ANTI-SMOKING ORDINANCES** in Wichita Falls, Texas was defeated at the ballot box, due to the efforts of the Wichita County Medical Society, the Texas Medical Association and the AMA.

●**MEDICARE IS THE HOTTEST ISSUE IN WASHINGTON** these days and experts say it will get even hotter during the 1996 elections. The Medicare fund will become insolvent sometime during the next decade, but Republican proposals for solving Medicare's budget woes are gathering criticism from many sides. The Republicans face a self-imposed deadline of a balanced budget by the year 2002, but health policy experts say cutting that much from Medicare would almost certainly mean charging beneficiaries more while squeezing payments to physicians and hospitals. Robert Reischauer, former director of the Congressional Budget Office, said "the notion that this can be squeezed out of the system with greater efficiencies is wishful thinking". In an interview in the *New York Times*, the Republican national chairman said the party will "go it alone" on cutting projected Medicare spending. He believes Republicans could reap the benefits if they can take credit for saving Medicare from bankruptcy. According to the AMA, his comments were the first indication the Republicans are contemplating unilateral action and party-line votes to redesign Medicare.

●**MEANWHILE, THE AMA IS PROPOSING** a complete transformation of Medicare. Dr. Nancy Dickey, vice chair of the AMA Board of Trustees, testified before the Senate Finance Committee regarding Medicare's insolvency problems. AMA's proposed Medicare reform follows five principles: 1) Encourage cost-consciousness among beneficiaries; 2) Increase price competition among providers; 3) Reduce intergenerational inequity in financing; 4) Test ways of reducing future generations' dependency on Medicare; 5) Reduce regulatory and administrative complexity.

FEATURE ARTICLE

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IMS, Iowa physicians focus on CHMIS

The Community Health Management Information System (CHMIS) will become law for Iowa physicians on July 1, 1996; in the interim, many details remain undecided. This month's feature discusses CHMIS issues of concern to Iowa physicians. Look on pages 243-44 for the complete text of IMS policy on CHMIS adopted April 30 by the IMS House of Delegates.



SCIENCE AND EDUCATION

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Duodenal web with preduodenal vein

The authors describe an unusual case of an infant with duodenal atresia and preduodenal portal vein without Down's syndrome.

● **SERGIO GOLOMBEK, MD; JAGADISH BILGI, MD;**
ONEYBUCHI UKABIALA, MD

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Service delivery to persons with HIV and AIDS

HIV-positive patients would benefit from pre and post-test counseling, say these authors. ● **EDWARD SAUNDERS, PhD; SUSAN DOLPHIN, MSW; BERRY ENGBRETSSEN, MD**

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Gary Nielsen, CPA

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Iowa Medicine



20th annual award of excellence in community service given to Dr. Paul Laube, Dubuque surgeon, Physician Community Service Award; Dr. Laverne Wintermeyer, former state epidemiologist, Des Moines, Merit Award; and Dr. Herman Hein, professor of pediatrics, UI College of Medicine, Iowa City, Ben T. Whitaker Award.

About the Cover

The 1995 IMS award winners are clockwise, from left—Dr. Paul Laube, Dubuque surgeon, Physician Community Service Award; Dr. Laverne Wintermeyer, former state epidemiologist, Des Moines, Merit Award; and Dr. Herman Hein, professor of pediatrics, UI College of Medicine, Iowa City, Ben T. Whitaker Award.

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Three important issues

Thoughts on loans for medical students, the recent visit of an AMA Trustee and a meeting with the IFMC. ● *THE PRESIDENT COMMENTS*

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Your help is needed!

A major fund-raising campaign will be initiated this fall for the IMS Education Fund. ● *PAUL SEEBOHM, MD*

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Late-breaking news of interest to Iowa physicians

●**THE IOWA MEDICAL SOCIETY** continues working with a group of large insurance companies and others to reach a consensus on a document entitled Patient Protection Act: Principles of Agreement under Managed Care. Besides the IMS, the group includes Deer & Company, Heritage, Blue Cross and Blue Shield, Principal Financial and the Iowa Hospital Association. Members of the group are now reviewing the final draft of the principles of agreement.

●**AN IOWA MEDICAL SOCIETY VIDEO ON PARTNER BATTERING** is complete and available for loan to any IMS member physician. The 27-minute video features Iowa experts on domestic abuse and would be ideal for a county medical society or hospital medical staff program. For more information, call Chris McMahon at the IMS, 800/747-3070.

●**DUE TO ITS COMPREHENSIVE EDUCATIONAL PROGRAM ON DOMESTIC VIOLENCE**, the Iowa Medical Society has been asked to participate in a national violence prevention conference to be held in Des Moines in late October. The Conference, entitled *Bridging Science and Program*, will be sponsored by the Centers for Disease Control and will be open to anyone interested in violence issues. Watch future issues of *Iowa Medicine* for more details.

●**CONTROVERSY OVER RULES GOVERNING PHYSICIAN ASSISTANTS** continues. During the 1995 legislative session, PAs introduced unsuccessful legislation to reduce the Board of Medical Examiners authority over physicians who supervise PAs. The IMS Board of Trustees has received a copy of a letter to Attorney General Tom Miller from the PA Board accusing the BME of usurping the authority of the PA Board. The BME has requested an attorney general's opinion to clarify the responsibilities of the two boards. The IMS has also submitted comments to the attorney general. The IMS believes the BME is the only board with the legal authority to regulate physicians.

●**THERE WAS MUCH TALK ABOUT VARIOUS PLANS TO RESTRUCTURE** Medicare at the recent AMA meeting in Chicago. Speaker of the House Newt Gingrich spoke to AMA delegates via satellite and outlined the Republicans' plan to "privatize" Medicare. The Speaker received several rounds of spontaneous applause from a packed house of physicians. You'll be hearing lots more about the AMA's Medicare proposal in coming issues of *Iowa Medicine* and in AMA publications.

●**"TEN DIRTY DIGITS"** was the title of a rather intriguing resolution introduced by the New York Delegation at the June AMA House of Delegates. The resolution cited the fact that the percentage of physicians who wash their hands between patients is 14-59% and called for the AMA to "campaign for improvements in hand-washing practices".

●**THE DEPARTMENT OF HUMAN SERVICES** has established a work group to consider changing the format of the Medicaid ID card and to review whether the monthly issuance of ID cards should continue. The group would like to hear comments from physicians on how eligibility could be verified if monthly cards were abolished. If you have comments, call Jan Walters at 515/281-6555 or mail your comments to the Department of Human Services, Division of Medical Services, 5th floor, Hoover State Office Building, Des Moines, 50319.

●**THREE IOWA PHYSICIANS WHO SERVED** as physicians in World War II are interviewed in the August *Iowa Medicine* about their experiences during the Normandy Invasion and the Battle of the Bulge. Don't miss their fascinating stories.

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Death, dying and Iowa law

When has enough medical care been given and when should nature be left to take its course? This article reviews Iowa law relating to life-sustaining procedures, durable power of attorney for health care and organ donation. ● *BECKY ROORDA, IMS MANAGER OF PUBLIC AFFAIRS*

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Latex allergy

Over the past five years, the FDA has received over 1,100 reports of injury and 15 deaths associated with latex allergy. ● *RK AGARWAL, MD; A AL-SILASH, MD*

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Thyrotoxic periodic paralysis

The author discusses the pathophysiology and management of TPP. ● *JOHN DiBAISE, MD*

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Principles of Medicare reform

The AMA has a viable plan for restructuring a program that's in financial trouble. ● *THE PRESIDENT COMMENTS*

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Organized medicine: it's for students, too

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IMS staying involved in the CHMIS process

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About the Cover

Dr. George Drake, a family practice physician with Iowa Physicians Clinic in Boone, examines Debbie Wibe of Madrid.

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Late-breaking news of interest to Iowa physicians

●**MEDICARE'S WOES HAVE BEEN UNDER THE MEDIA SPOTLIGHT** lately and dramatic statements made by politicians are causing consternation among the elderly, many of whom have little understanding of the issue. Watch your mail next month for a patient information sheet prepared by the Iowa Medical Society for member physicians who are getting questions from patients about the future of Medicare. The information sheet, suitable for copying, answers basic questions about problems in the Medicare program. The AMA is staying closely involved in the process and has been asked several times to present testimony at committee hearings. As of press time, the AMA was pursuing an opportunity to present its plan to the Senate Finance Committee.

●**MEDCO, THE COMPANY RETAINED BY THE STATE OF IOWA** to provide managed mental health care to Title 19 patients, is now in its sixth month of operation here. An article in the September *Iowa Medicine* examines Iowa's first experience with big time managed care and discusses concerns over some of the company's policies.

●**NEW JERSEY GOVERNOR CHRISTINE TODD WHITMAN** has signed into law a bill that requires insurers and HMOs to pay for at least 48 hours of hospital care after a routine delivery and 96 hours after a C-section. The law, which takes effect immediately, exempts health plans that provide home health services, but only if the mother and her physician agree on a home visit. In June, the AMA House of Delegates expressed concern over shortened OB stays, but is also concerned over laws which dictate what should be a physician/patient decision. Check the September *Iowa Medicine* for more information on the AMA/IMS policy on obstetrical hospital stays.

●**DESPITE INTENSE EFFORTS BY THE TEXAS MEDICAL ASSOCIATION**, Governor Bush has vetoed the Texas Patient Protection Act. Governor Bush has directed the Texas insurance commissioner to develop regulations that protect patients and physicians. The Iowa Medical Society has been working with representatives of Heritage, Blue Cross Blue Shield and Principal on voluntary adoption of the principles in the AMA's Patient Protection Act. As of press time, an agreement was close to being struck.

●**UNFORTUNATELY, SMOKING AMONG YOUTH IS ON THE RISE**, according to a new federally funded study. Smoking among youth is up as much as 30% and smoking among 8th graders jumped 30% from 1991 to 1994. Almost one in every five 13 and 14-year-olds is a sometime smoker.

●**THE IOWA MEDICAL SOCIETY WILL PARTICIPATE IN A NATIONAL** anti-violence conference sponsored by the Centers for Disease Control. (See page 314.) The conference is open to physicians and registration information is now available. The conference, entitled "Bridging Science and Program", will be held October 22-25 at the Des Moines Convention Center and is expected to draw participants from around the country. For registration information, call the National Conference Organizers at 404/488-4647 or fax 404/488-4349. The conference is cosponsored by the University of Iowa Injury Prevention and Research Center and CMEs will be available. The IMS presentation will be on domestic violence.

●**THE FIRST MEETING OF THE VIOLENCE AGAINST WOMEN ADVISORY COMMITTEE** was held recently, cochaired by HHS Secretary Donna Shalala. In her opening statement, Secretary Shalala praised the AMA's efforts in the area of violence prevention.

FEATURE ARTICLE

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Physicians on the front line

This year marks the 50th anniversary of the Allied victory over Hitler. Drs. Ralph Dorner, John Hess and Robert Stickler served as physicians during the invasion of Normandy and the Battle of the Bulge and have a unique perspective on these historic events.

● *CHRISTINE McMAHON, IMS DIRECTOR OF COMMUNICATIONS*



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AMA delegates determine medicine's agenda

The AMA House of Delegates, including members of the Iowa delegation, approved policy on Medicare reform and other weighty issues at the June meeting in Chicago. Check out this summary of key actions.

SCIENCE AND EDUCATION

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Air pellet gun injury

Air gun missile injuries in children can be associated with significant mortality and morbidity. ● *DANIEL WATERS, DO; BENJAMIN BROGHAMMER, MD; R. MARK DUFF, MD*

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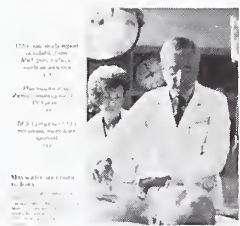
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Iowa Medicine



About the Cover

Pictured on this month's cover is Kenneth Schultheis, DO, a Des Moines emergency physician. Photo provided by Mercy Hospital Medical Center.

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The corporatization of health care

A physician's responsibility to patients can sometimes clash head-on with economic concerns. ● *THE PRESIDENT COMMENTS*

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In the news

Iowa Medicine, Journal of the Iowa Medical Society (ISSN 0746-8709), is published monthly by the Iowa Medical Society. Subscription price: \$25 per year. Second class postage paid at Des Moines, Iowa and at additional mailing offices. POSTMASTER: Send address changes to *Iowa Medicine*, Journal of the Iowa Medical Society, 1001 Grand Avenue, West Des Moines, Iowa 50265. NATIONAL ADVERTISING: State Medical Publishers Network, 9534 Marshall Drive, Shawnee Mission, Kansas, 66215-1354, phone 913/888-8781. IOWA ADVERTISING: Jane Nieland, *Iowa Medicine*, 1001 Grand Avenue, West Des Moines, Iowa 50265. Phone 515/223-1401. EDITORIAL CONTENT: The Society is unable to assume responsibility for the accuracy of that which is submitted. Manuscripts or editorial inquiries should be directed to the Editor, *Iowa Medicine*, 1001 Grand Avenue, West Des Moines, Iowa 50265. Copyright 1995 Iowa Medical Society.

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Late-breaking news of interest to Iowa physicians

●**DON'T MISS THE STORY ON IOWA'S NEWEST MANAGED CARE EXPERIENCE** which begins on page 364 of this *Iowa Medicine*. This status report on managed mental health care for Title 19 patients looks at a number of interesting and difficult issues for providers.

●**WATCH YOUR MAIL THIS MONTH** for special Medicare educational materials being provided by the IMS for member physicians. The IMS has created a one-page Q & A piece for patients who don't understand basic Medicare issues. It is suitable for copying. The mailing will also include information for physicians only regarding the AMA's Medicare proposal.

●**DEAN GILLASPEY, CAE**, vice president of operations and medical economics for the Iowa Medical Society, has been elected to a two-year term on the board of directors of the American Association of Medical Society Executives (AAMSE). He was installed at the AAMSE annual meeting in August.

●**AN INFLUENTIAL GROUP OF 22 MINNESOTA EMPLOYERS** has decided that bigger isn't better when it comes to health plans. The employers will now negotiate directly with smaller, organized groups of doctors and hospitals and give employees information on cost, quality and consumer-service performance. The employees will receive monthly vouchers toward premiums and will shop among the competing groups. A spokesman for the employers said their goal was to "get employers and health plans out of the middle" of transactions between doctors and patients.

●**BLUE CROSS AND BLUE SHIELD CEO ROBERT RAY** announced his retirement late last month and the search has begun for his replacement. Top candidates now being mentioned include Blues senior officers Duane Heintz (senior vice president, provider network); Craig Hennessy (chief operating officer); Robert Millen (chief development officer); and Richard Stilley (chief administrative officer). Robert Ray will step down at the end of 1996.

●**THE PRESIDENT, THE AMA AND OTHER CONCERNED GROUPS** held a joint press conference recently to call for federal regulation of tobacco. At least 100 organizations have sent petitions to the White House; 40 conservative Republican doctors sent a letter to House Speaker Newt Gingrich urging that the issue be considered as a health concern, not a political one. Meanwhile, House Minority Leader Richard Gephardt has joined forces with tobacco-state Democrats to block any White House plans to extend federal regulations to cigarettes.

●**THE AMA HAS BEEN A VISIBLE PRESENCE ON THE HILL** recently, touting the merits of the AMA Medicare transformation proposal and presenting testimony on important issues ranging from domestic violence to tobacco. AMA Board of Trustees member Tim Flaherty, MD, appeared before the Senate Labor Committee as it received testimony on a bill which would outlaw the emerging insurance industry practice of terminating the coverage of victims of domestic violence.

●**THE IOWA MEDICAL SOCIETY IS PARTICIPATING** in a group which is studying 24-hour post-partum discharge. The group, which is working through the Des Moines Infant Mortality Prevention Center, will conduct a survey of mothers four to eight weeks following discharge from the hospital. The survey will begin in early 1996.

FEATURE ARTICLE

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Managed care comes to Iowa

The state of Iowa and Iowa psychiatrists are six months into Iowa's first major experience with managed care. This article discusses Title 19 managed mental health care as it is being administered by Medco Behavioral Care. Physicians and others have concerns about the effect the program might have on patients.

● *CHRISTINE McMAHON, IMS DIRECTOR OF COMMUNICATIONS*

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Metastasis of adenocarcinoma of breast to gluteus medius

The authors describe an unusual case of rapid progression of infiltrating ductal carcinoma to multiple sites.

● *SUBHASH SAILAI, MD; DARCY LEIGH, DO*

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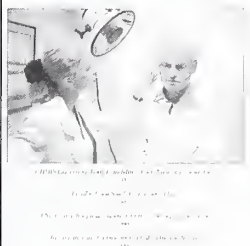
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About the Cover

Sharen Sabin, MD, a dermatologist practicing in Dubuque, examines Wayne Jewett, also of Dubuque. Photo provided by Karen Knepper of Finley Hospital.

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Why I belong

IMS president Joseph Hall, MD discusses some of the incentives for membership in the Iowa Medical Society and involvement in organized medicine. ● *THE PRESIDENT COMMENTS*

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Late-breaking news of interest to Iowa physicians

● **IOWA MEDICINE'S SEPTEMBER STORY ON MEDCO** was quoted in a front page September 18 story by *Des Moines Register* reporter Bill Leonard. The story, entitled "**Managing mental health: Sacrificing the poor to save a few bucks?**", explored complaints about the managed care company in charge of providing mental health care to Iowa's Medicaid patients. IMS leadership and staff are continuing to meet with representatives of Medco, the Iowa Department of Human Services and the Governor's office to try and work out problems. We'll keep you posted. Any physician who missed the *Register* story can get a copy by calling Chris McMahon at the IMS, 800/747-3070 or 515/223-1401.

● **IN THE NOVEMBER IOWA MEDICINE**, Congressman Greg Ganske discusses the goings-on in our nation's capitol, specifically in the area of Medicare reform. Congressman Ganske will discuss the Republican plan for reforming Medicare and feedback he received at recent town meetings held across Iowa. The Republican plan reportedly calls for an annual \$50 increase in deductibles for doctor services as well as 20% of charges for lab tests, home health and some skilled nursing facility services.

● **A CONTINGENT OF IMS LEADERS** went to Washington, DC this week to meet with Iowa's congressional delegation and to attend an AMA grass roots political education conference. IMS leaders planned to meet with congressmen to discuss Medicare and Medicaid reform.

● **THE ISSUE OF HOW MUCH INFORMATION SHOULD BE MADE PUBLIC** when a physician is charged by the Board of Medical Examiners has hit the news lately. The IMS has filed a petition of intervention in the John Doe II case. The IMS position is that the statement of charges (a public document) should contain only the physician's name, the date of the occurrence and the statute the physician is alleged to have violated. IMS leaders plan to meet soon with representatives of the BME to discuss issues of mutual concern.

● **DON'T FORGET THAT THE GREAT AMERICAN SMOKEOUT** is November 16. What's the best advice for your patients about quitting? Richard Corlin, MD, a member of the AMA Board of Trustees, tells patients to switch brands with every pack they buy. "I tell them to buy a brand they've never smoked and to smoke the entire pack, even if they don't like the taste." The theory is that some people continue smoking because they like the taste of a particular brand.

● **A MAJOR TRANSFORMATION OF THE AMA'S CPT CLEARINGHOUSE** is underway. Since it opened in 1991, it has served as an excellent resource for physicians seeking interpretation of CPT codes. The Clearinghouse is undergoing reorganization because the number and complexity of inquiries was beginning to be overwhelming. During the reorganization, the Clearinghouse cannot respond to telephone or written requests. The Clearinghouse will reopen in late October for AMA members.

● **THERE WILL BE A SPECIAL FEATURE ON MEDICARE CODING** by Iowa physicians in the November *Iowa Medicine*. E & M coding documentation guidelines from the Health Care Financing Administration have been released; don't miss this first look at how Iowa physicians appear to be complying with the guidelines.

● **A NUMBER OF GOVERNMENT MATERIALS** can now be found on Internet's World Wide Web. These include the *Federal Register*, the *Congressional Record*, the *US Code* and other information. The Web address is: <http://ssdc.ucsd.edu/gpo>.

FEATURE ARTICLE

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Bound by common interests

A vigorous physician-owned delivery system can retain market share which hospitals by themselves could lose to larger centers.

● COOPER PARKER, PHYSICIAN NETWORK MANAGEMENT, INC.

SCIENCE AND EDUCATION

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Alzheimer's disease: the role of tacrine therapy

The author discusses criteria for tacrine therapy, the only agent approved for treatment of Alzheimer's Disease.

● GERALD JOGERST, MD

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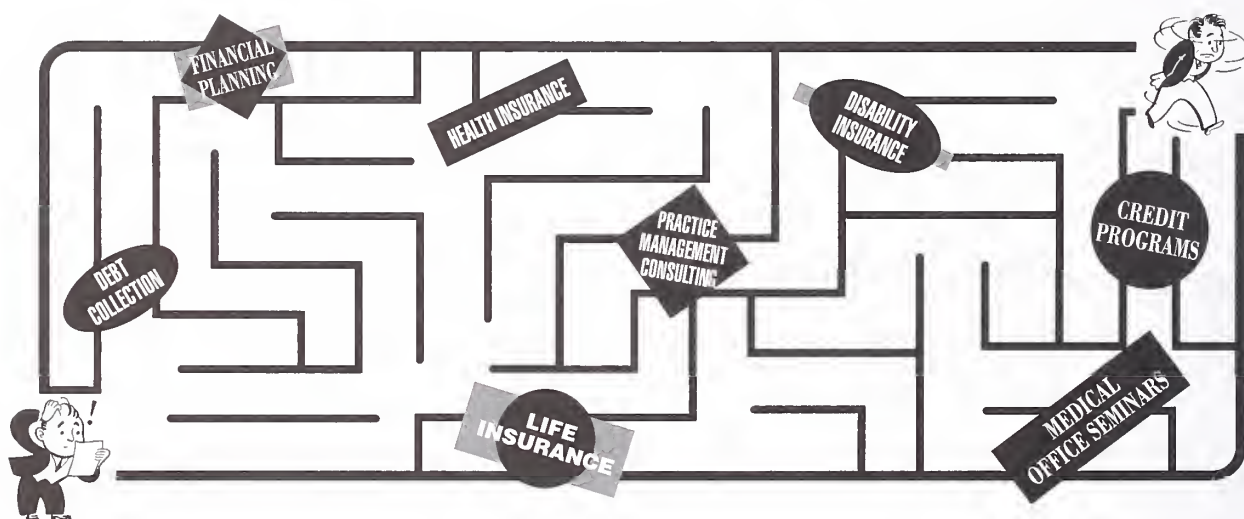
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PACs are a reality

In an ideal society, PACs would not be needed. Unfortunately, we don't live in an ideal society. ● *THE PRESIDENT COMMENTS*

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The right to privacy vs. the public's right to know

A legal battle involving Iowa physicians and the Iowa State Board of Medical Examiners has been much in the news lately. The IMS president discusses the Society's position. ● *JOSEPH HALL, MD*

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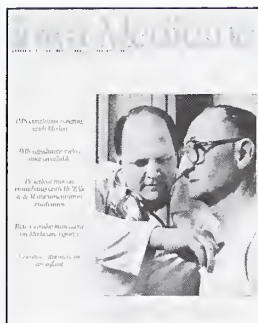
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About the Cover

Jeff Boyd, MD examines a patient. Dr. Boyd is an Iowa Heart Center cardiologist who practices at the Ames McFarland Clinic.

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Late-breaking news of interest to Iowa physicians

●**ARE YOU AT RISK?** Don't miss the feature on Stark II provisions in the December *Iowa Medicine*. Three attorneys discuss what Stark II means to physicians' practices now and what it will mean in the future.

●**AS OF PRESS TIME (10/25)**, a majority of Iowa's congressional delegation had voted in favor of the Republican plan to reform Medicare. Iowa Congressmen came on board after Speaker Gingrich made concessions on the urban-rural differential in payment for Medicare managed care plans. Gingrich agreed to raise the floor to a minimum \$300 per-month charge. The AMA is supporting the GOP plan, saying it will empower patients to make their own choices and that it recognizes the extraordinary value of physicians in managing and delivering health care. The plan will also "remove red tape and liability barriers that disturb the patient-physician relationship", says the AMA. Physicians are cautioned not to take as gospel all the media reports on the Medicare debate. Some are erroneous or tell only part of the story.

●**SCAM ARTISTS ARE MOVING INTO THE MANAGED CARE ARENA** and IMS has heard recently of several Iowa physicians receiving solicitations for questionable managed care enterprises. Physicians are cautioned to send no money until you check a company's credentials.

●**IMS HAS RECEIVED NOTIFICATION** that Blue Cross and Blue Shield will raise the base rate for its Statewide Physicians Group Health Plan by 13.8% in 1996. Rates could be further adjusted (up or down) depending on demographics. The IMS Committee on Member Services plans to meet with Blues officials this month to discuss the factors behind the rate hike.

●**THIRTY PERCENT OF BABIES IN THE U.S.** are born out of wedlock, up from 18% in 1980, according to a recent Kiplinger Newsletter. Experts believe the number of babies born to unwed mothers will continue to rise, a trend which has far-reaching implications for America's schools, health care system and employers.

●**THERE HAS BEEN A SLEW OF CONGRESSIONAL RESIGNATIONS AND RETIREMENTS** led by GOP Sen. Packwood and Democratic Rep. Reynolds, both stepping down due to scandals. Democratic Rep. Mineta of California will become a Lockheed exec. Eight senators (one Republican and seven Democrats) and 12 House members (four Republicans and eight Democrats) also plan to leave at the end of 1996. Political analysts theorize this will further reduce Democratic changes of taking control of Congress after next year's elections.

●**THE IOWA MEDICAL SOCIETY** Board of Trustees met last week with members of the CHMIS Executive Committee to get an update on the progress of CHMIS implementation. The CHMIS is scheduled to be operational in Iowa July 1, 1996. CHMIS committee members addressed a number of questions and concerns. Board members were particularly interested in the issues of how much of the cost of CHMIS will be borne by physicians, verification of insurance eligibility and the ethical implications of collecting sensitive and/or confidential information from patient records and placing it in a data repository. At its October meeting, the IMS Board also decided the IMS will be unable to meet requirements to become the CHMIS data repository and will not bid on the project. This information was shared with the IMS Committee on CHMIS at that group's October meeting.

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E & M documentation — is Iowa complying?

Practical advice from the co-chairs of the Medicare Carrier Advisory Committee on Iowa compliance with HCFA documentation guidelines. ● *JOHN OLDS, MD; KENT MOSS, MD*

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Greg Ganske on Medicare reform

The text of a statement read by Rep. Ganske October 2 when the Medicare Preservation Act was introduced in the House Commerce Committee. ● *CONGRESSMAN GREG GANSKE*

SCIENCE AND EDUCATION

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Apnea and vomiting due to cocaine exposure

Case report of an infant with apnea and vomiting as a result of passive exposure to cocaine. ● *ENEHOMERE OKORUWA, MD; RIZWAN SHAH, MD; KAREN GERDES, MD*

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EDITORIALS

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AMA's role in the Medicare reform bill

At a recent meeting of the North Central Medical Conference, AMA President Lonnie Bristow, MD discussed the AMA's efforts to improve the Medicare conversion factors.

● *THE PRESIDENT COMMENTS*

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Farewell to a friend

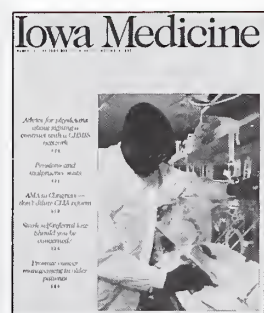
After 43 years with the Iowa Medical Society staff, Tina Preftakes is retiring December 31. ● *A SPECIAL TRIBUTE*

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Dr. Onyebuchi Ukabiala examines a premature baby. Photo provided courtesy of Mercy Hospital Medical Center, Des Moines.

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Late-breaking news of interest to Iowa physicians

●**MANAGED CARE WILL BE THE FOCUS OF A BRAND NEW SECTION** in *Iowa Medicine* which debuts in January. The two-page section will be entitled "Managed Care – News You Can Use". The new section will highlight topics such as practice parameters, managed care liability and the ethics of managed care. The section will also contain information about resources available from the IMS for its member physicians.

●**CONGRATULATIONS TO DR. ROGER CEILLEY** who was recently elected president-elect of the American Academy of Dermatology for 1996. Dr. Ceilley practices in West Des Moines.

●**IOWA'S MEDICARE CARRIER HAS MAILED 1996 FEE SCHEDULES** and the "Dear Doctor" letter. Physicians who wish to change their participation status must return the Dear Doctor letter postmarked by December 31. (Keep a copy and send the letter certified mail to document the postmark.) The fee schedules as mailed were based on three separate conversion factors. If Congress and the President can agree, it appears we may move to a single conversion factor as part of Medicare reform and the fee schedules for 1996 would have to be recalculated. If you have questions, call Barb Cannon Heck of the IMS staff.

●**THE DEPARTMENT OF HUMAN SERVICES** has decided to scuttle a plan to bundle diagnostic lab and ultrasound charges into Medicaid's obstetrical global billing (Physicians Informational Release no. 95-5) without an increase in the global fee. When the plan was announced, IMS staff estimated the services being bundled could total \$500. IMS approached the DHS to voice extreme concern on behalf of Iowa physicians and the DHS reevaluated the decision. Physicians will receive a letter of explanation from Unisys – the Medicaid fiscal intermediary – completely rescinding the policy. If you have questions, call Barb Cannon Heck of the IMS staff.

●**THE IMS DOMESTIC VIOLENCE VIDEO** has won honorable mention in the Golden Circle Awards sponsored by the American Society of Association Executives. "Break the Silence; Begin the Cure" was produced by the IMS Task Force on Domestic Violence and competed against over 40 videos submitted by associations from all over the country.

●**LOOK ON PAGE 476 OF THIS IOWA MEDICINE** for important advice about choosing a CHMIS network so you will be prepared for the July 1, 1996 start of CHMIS implementation. There will be no certified networks as of July 1, and it is imperative that you understand what this means for your practice before vendors begin their marketing efforts.

●**POLITICAL SURVIVAL SKILLS** will be the focus of a workshop planned for Wednesday, January 17 at IMS headquarters. Keynote speaker will be Michael Dunn, a political consultant based in Washington, DC. The workshop fee is \$25. To register, call Sandy Nichols at the IMS, 800/747-3070.

●**THE BLUES HAVE MAILED PHYSICIAN PROFILES** to Blue Advantage Network physicians. Using 1994 Blue Shield claims data, the report compares practice patterns of individual physicians to other network physicians and specialties. A survey was mailed with the report. Physicians are encouraged to carefully review the report and return the survey so the Blues will receive feedback on the validity of the physician profiles. Contact Ed Whitver of the IMS staff if you have questions on IMS activities in the data/technology area.

FEATURE ARTICLE

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Stark self-referral law

In September, after nearly a four-year delay, regulations for Stark I took effect. Should Iowa physicians be concerned about the effect of Stark on their practices? These authors say they should.

● STEVEN BECK, JD; DAVID GLASER, JD

SCIENCE AND EDUCATION

489

Prostate cancer management in older patients

Use of radical prostatectomy as definitive therapy has increased dramatically in the past decade. However, there is a controversy regarding the optimal management of this malignancy in older patients. ● WILLIAM SEE, MD

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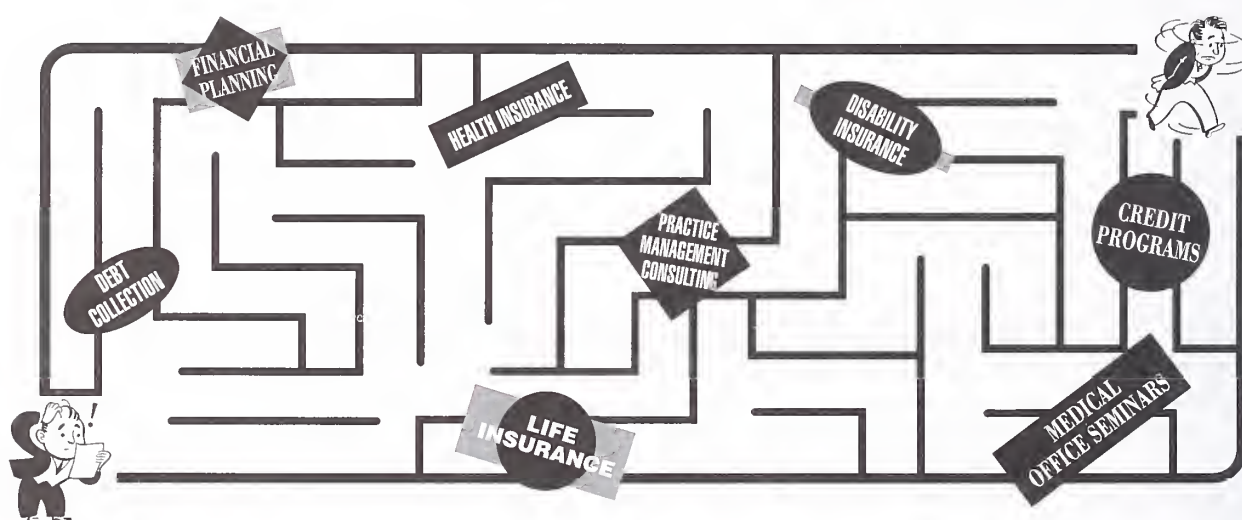
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1001 Grand Avenue, West Des Moines, Iowa 50265

Watch for red flags

I conducted an informal survey in the doctors' lounge and found a number of physicians with a story on domestic violence. It's not every day that physicians see domestic violence, but it occurs frequently enough that each physician could recall a case. One physician admitted he should consider domestic violence more frequently and that may be true for many of us.

A general surgeon recalled a woman whose life was saved by surgical intervention after she was stabbed. To the chagrin of the surgeon, the patient returned to the live-in friend who knifed her. The case points out the physician's frustration and why more understanding and knowledge on dealing with these cases is necessary.

Another physician, an internist, tells of a middle-aged woman he saw many times for minor injuries. She attributed the minor fractures and bruises to accidents which occurred while caring for her grandchildren. "I just can't keep up with them any longer," she would say. Finally, he received a phone call from her and she was staying at

the battered women's shelter. For the first time, the true story came out. She had been abused by her husband for years. This case indicates the need to routinely screen for abuse, be alert for red flags and ask the right questions.

When you see a suspicious injury, interview the patient alone and ask a direct question. Remember, an abusive partner may come with the patient and insist on staying close. An

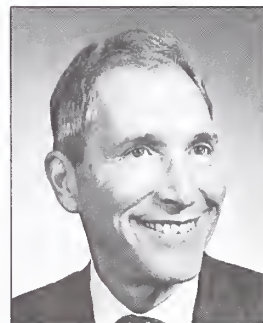
overly solicitous partner—eager to explain the injury and answer the questions—is suspect. The following are examples of questions that should be asked: Do you feel safe in your home? Are you in a relationship in which you feel you are badly treated? Has your partner ever prevented you from leaving the house, seeing friends, getting a job or continuing your education? Do you feel you have to walk on eggshells around your partner?

Even in my otolaryngology practice, I had an experience with child abuse. A family physician from out of town referred a preschooler on a Friday evening, supposedly for ear lacerations that needed suturing. When the little girl was seen in the emergency room she had tears behind the ears extending into the fascia. Close

It occurs frequently enough that each physician could recall a case.

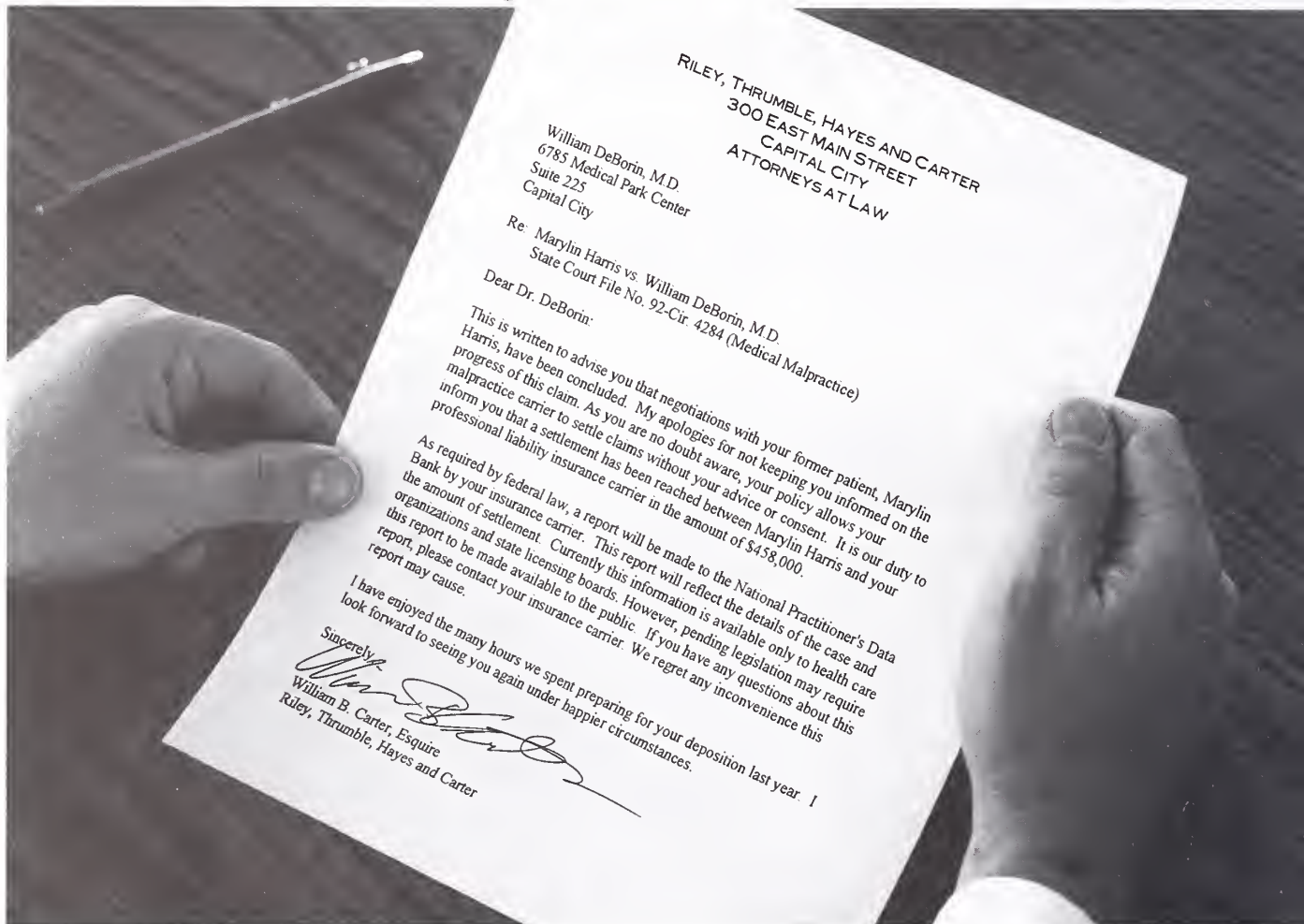
inspection indicated fingernail marks in front of the ears. The mother said her son had just picked the patient up from preschool. I showed the mother how the ears were probably pulled, causing the injury. The mother confronted the teacher, who confessed that she disciplined the little girl. The child was removed from the preschool.

Physicians are in a distinct position to identify battered women and other victims of domestic violence. However, we can't do it alone. We should check to see if our hospital emergency departments have a way to identify and support the battered patients and become familiar with community support groups. **IM**



JAMES WHITE, MD

Medical Protective Policyowners NEVER get letters like this!



RILEY, THRUMBLE, HAYES AND CARTER
300 EAST MAIN STREET
CAPITAL CITY
ATTORNEYS AT LAW

William DeBorin, M.D.
6785 Medical Park Center
Suite 225
Capital City

Re: Marilyn Harris vs. William DeBorin, M.D.
State Court File No. 92-Cir. 4284 (Medical Malpractice)

Dear Dr. DeBorin:

This is written to advise you that negotiations with your former patient, Marilyn Harris, have been concluded. My apologies for not keeping you informed on the progress of this claim. As you are no doubt aware, your policy allows your malpractice carrier to settle claims without your advice or consent. It is our duty to inform you that a settlement has been reached between Marilyn Harris and your professional liability insurance carrier in the amount of \$458,000.

As required by federal law, a report will be made to the National Practitioner's Data Bank by your insurance carrier. This report will reflect the details of the case and the amount of settlement. Currently this information is available only to health care organizations and state licensing boards. However, pending legislation may require this report to be made available to the public. If you have any questions about this report, please contact your insurance carrier. We regret any inconvenience this report may cause.

I have enjoyed the many hours we spent preparing for your deposition last year. I look forward to seeing you again under happier circumstances.

Sincerely,

William B. Carter, Esquire
William B. Carter, Esquire
Riley, Thrumble, Hayes and Carter

Any allegation of malpractice against a doctor is serious business. If you are insured by The Medical Protective Company, be confident that in any malpractice claim you are an active partner in analyzing and preparing your case. We seek your advice and counsel in the beginning, in the middle, and at the end of your case. In fact, unless restricted by state law, every individual Medical Protective professional liability policy guarantees the doctor's right to consent to any settlement--no strings attached! In an era of frivolous suits, changing government attitudes about the confidentiality of the National Practitioner's Data Bank and increased scrutiny by credentialing committees, shouldn't you have The Medical Protective Company as your professional liability insurer? Call your local General Agent for more information about how you can have more control in defense of your professional reputation.

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Give the gift of hope

I congratulate you and your Iowa colleagues in organized medicine for your efforts to educate all Iowa physicians regarding domestic violence. Because a physician may be the first non family member to whom an abused woman turns, physicians have a unique ethical responsibility to intervene.

As we enter a new year, we can make a special effort to help those who are striving to escape the bonds of family violence. While our campaign to educate physicians and the public about domestic violence is successful, it also increases the demand on the shelters that care for battered women and children.

But donations to these islands of safety have not increased to meet the new demand. In light of the rising awareness, you may ask: Why aren't more people giving? According to Ann Kaplan, editor of *Giving USA*, "It's easier to give to a specific, well publicized event than to a diffused need like poverty or (to survivors of family) violence."

What can individual physicians and medical societies do to help?

We can help support our patients' decision to become survivors.

We can help support our patients' decision to become survivors in 1995. We can give the gift of hope.

Here are some suggestions:

- Make 1995 a truly new year for a victim of domestic violence by giving financial support for counseling and advocacy services to your local shelter or community outreach service.

- Give gift certificates from supermarkets and

discount stores to shelters and community outreach services. This helps them provide sheltered women and children with fresh milk, dairy products, produce, meat, shoes and needed household items all during the year.

- Donate gift items like new clothing for women and children to the shelters; also unwrapped non-violent toys, books and games. Most shelters will display these items so mothers can choose suitable ones for themselves and their children.

- Adopt a shelter. Shelters need bed linens, blankets, towels and washcloths all during the year. They will accept used items that are clean and in good condition. Linens for baby cribs, single and bunk beds top their list.

- Call your local battered women's shelter and ask what you can do to help. The IMS staff has a complete list of shelters in Iowa.

Since the IMS Board of Trustees has identified domestic violence as a priority issue, in December the IMS staff chose the local domestic violence shelter for a holiday giving project. Staff members donated clothing, toys and other personal items sorely needed at the shelter.

I thank you, your medical society and physician members for your strong support in the campaign to end family violence. Thank you, too, for joining me in taking another step down this long road. Physicians can do much to assure shelters and family services are there to help us protect our patients from abuse. **IM**



ROBERT MCAFEE, MD
AMA president

Dr. McAfee, a surgeon practicing in Maine, has identified domestic violence as his issue of focus during his presidential term.

“Organizing for Change” cassette tapes available

“Be creative, but go into any arrangements with your eyes open, recognizing there are not going to be any absolute winners.” KEN DAVIS, JD

“You have to be able to negotiate with the big gorillas in the marketplace.” BILL DEMARCO

“Hospitals have been a driving force in rural Iowa because of the small number of physicians.” ED MCINTOSH, JD

“As managed care makes further inroads in Iowa, having a good information system will be critical to the success of any PO.” TOM GOREY, JD

“When the American public sees what is happening to their freedom of choice, there will be a public backlash against managed care.” JAMES TODD, MD, EXECUTIVE VICE PRESIDENT, AMA

Here's what Iowa physicians said about the expert presentations at “Organizing for Change”

“The speakers were well-focused and authoritative. A high quality meeting.”

“I wish all Iowa physicians could hear this program.”

“Excellent hands-on information.”

“Very high quality program. Keep them coming.”

“Plenty of useful, practical advice. Almost too much to take in.”

“The speakers' level of knowledge and insight was impressive.”

If you missed the “Organizing for Change” conference, you can order a set of cassette tapes containing the entire day's program, including Dr. James Todd's entertaining luncheon presentation. The cost of the tapes and related materials is \$42.00. The set of cassettes without related materials is \$26.25. To order, use the order form below or call Barbara Heck or Linda Tideback at the IMS, 515/223-1401 or 800/747-3070.

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Price includes shipping, handling and taxes. Prepayment is required. Please make check payable to the Iowa Medical Society. Mail check and order blank to: Iowa Medical Society, 1001 Grand, West Des Moines, IA 50265. Attn: Linda Tideback.

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A mass media reality check

It is well-documented that repeated exposure to a particular behavior can cause a person to emulate that behavior. Repeated exposure to violence in the mass media, particularly at young ages, can have lifelong consequences. Nearly four decades of research by the APA Commission on television viewing and other media are conclusive: Higher levels of viewing violence in the mass media are correlated with increased aggression in children and increased acceptance of aggressive attitudes by children.

Depictions of sexual violence, primarily in R-rated films and messages about violence against women appear to influence attitudes of adolescents about rape and violence toward women. These attitudes carry over into adult life. Such behavior is often acted out as spouse abuse or other serious criminal behavior.

While politicians and TV executives argue over whether or not TV violence should be reduced, over 200 studies tell us there is reason to be concerned. Research shows that by the time the average child turns 18 years of age, he or she will have spent 11,000 hours in school and more than 15,000 hours watching television. To put this TV time in perspective, a person could graduate from both medical and law schools utilizing the same number of hours studying. Instead, a child may see 22,000 acts of television violence by age 13 and 80,000 by age 18.

Statistics also show that in the past 30 years,

violence has replaced disease as the number one killer of children. Teenagers are approximately two and one half times more likely to be victims of violent crime than they were 20 years ago. The homicide rate among teens from 1984 to 1993 increased 121% for 17 year olds, 217% for 15 year olds and 100% for children under 12, according to the National Crime Analysis Project at Northeastern University.

If violence on TV is a major contributor to the violence on our streets and in our homes, physicians should look on TV with the same concern they have for a contagious disease.

The IMS Alliance offers you the opportunity for a "reality check" by viewing the AMAA video, "Violence in America." This video is a powerful three-minute presentation featuring

**Violence
has replaced
disease as
the number
one killer
of children.**

actual clips from movies, television shows, media reports and children's cartoons that graphically depict why violence in America has reached epidemic proportions. It is narrated by Tom Browkaw with the plaintive strains of a woman singing chilling words in the background: "Didn't anybody tell them that's not how it has to be?" The video is available for purchase or for a two-week "free" rental through the IMSA.

The Alliance is committed to our goal of "Zero Tolerance for Violence"; violence in the media is just one of our many targets. We are pleased to make this video available to you. **IM**



BARBARA BELL
President
IMS Alliance

**Break
the
Silence**



Begin the Cure

IMS Update

AT A GLANCE

Robert Kelch, MD, the new dean of the University of Iowa College of Medicine, will be the guest luncheon speaker at the Thursday, January 12 meeting of the IMS Executive Council. Edward Howell, director of the UI Hospitals and Clinics, will also give a presentation.

A second IMS dues mailing was sent in mid-December. If you haven't yet paid your IMS dues, your prompt attention to this matter will be appreciated.

Updated copies of the IMS Articles of Incorporation and Bylaws are available by calling Sandy Nelson at IMS headquarters, 515/223-1401 or 800/747-3070.

IMS Annual Meeting April 28-30

The 1995 IMS House of Delegates and Scientific Session will be Friday-Sunday, April 28-30 at the Marriott Hotel in Des Moines. Make your room reservations by calling the Marriott at 800/228-9290.

The House of Delegates meets Saturday at 8:30 a.m. and Sunday at 10 a.m. County societies should be identifying their delegates to the 1995 House. Each county is entitled to at least one delegate and one alternate, with one additional delegate and alternate per 15 active, resident or life members.

Any member can submit a resolution for consideration by the 1994 House. Resolutions must be sponsored by a county society, a delegate or a Councilor District and may address any issue concerning medical care or practice.

1995 IMS offices to be filled by the House include (length of term in parenthesis): president-elect (1); vice-president (1); trustee (3); House speaker and vice speaker (1); AMA delegate (2) and AMA alternate (2). Judicial Councilors in Districts 1, 6, 9 and 13 (all two-year terms) are also up for election.

Below is the District caucus schedule. If no information was available from your district at press time, call Barb Walker at the IMS, 800/747-3070.

Nominees wanted for physician award

IMS is seeking nominees for its Physician Award for Community Service. The award will be presented during the 1995 House of Delegates. The award honors an Iowa physician who has provided outstanding civic, charitable and health services. Service should be uncompensated. The deadline is March 1.


Anyone can nominate a physician by writing to Tina Prefakes at the IMS, 1001 Grand, West Des Moines, IA 50265.

Give the physician's name and address, a picture of the physician and a description of why he or she should be considered. The recipient will be chosen by the IMS Trustees.

Clinic manager award nominees sought

Nominees are being sought for the 1995 Outstanding Iowa Medical Office Administrator Award.

A panel of member physicians will select the winner and the award will be presented at the IMS House of Delegates April 28-30 at the Marriott Hotel in Des Moines.

To nominate a clinic manager for this award, call Dana Petrowsky at IMS Services, 515/223-2816 or 800/728-5398 by February 15. 

IOWA MEDICAL SOCIETY 1995 DISTRICT CAUCUSES

Dist.	Date	Location and Time	Councilor
1	1/25	Pzazz in Burlington, 6:30 pm	Robert Kent, MD
2	2/1	Highlander, Iowa City, after business meeting	William Bonney, MD
3	2/9	River City Cafe, Davenport, 7 pm	Eugene Kerns, MD
4	1/10	Mercy Cafeteria, Cedar Rapids, after 7 pm meeting	Albert Coates, MD
5	1/24	Knight-Light Supper Club, Dyersville, 6:30 pm	Ross Madden, MD
6	2/14	Prime N Wine in Mason City, 6:30 pm	John Justin, MD
7	2/7	Star Lite Hotel in Waterloo, after business meeting	Steven Erickson, MD
8	1/12	Steak Center in State Center at 6 pm	Leo Milleman, MD
9	1/3	Ottumwa Country Club in Ottumwa at 6 pm	Jay Heitsman, MD
10&11	1/24	Glen Oaks in West Des Moines at 6 pm	Michael Disbro, MD
12	Contact IMS for site information		C. David Smith, MD
13	1/9	Stewart Memorial Comm Hosp, Lake City at 7:30 pm	John Fernandez, MD
14	1/26	The Hotel in Spencer at 7 pm	Linda Iler, MD
15	2/16	Sioux City Country Club, 6 pm social hour, 7 pm dinner	Stephen Richards, DO
			Kathryn Opheim, MD

Futures

Is health system reform a dead issue?

USA Today and other major newspapers predict the Republican Congress is not likely to drop health system reform entirely.

Republicans may attempt smaller changes such as insurance reforms that would ban denial of coverage for pre-existing conditions, medical malpractice reform or tax relief for health care spending.

The White House is also revamping its approach to reform in the wake of the elections. The President may fold health reform into the federal budget next year instead of sending Congress a massive piece of legislation. This would give the White House a better chance at passing at least part of the plan.

There is talk around Washington that White House Chief of Staff Leon Panetta will take over the job of top Clinton advocate for health system reform legislation this year.

Experts predict that, if health reform does re-emerge, it could well be in the context of a broader debate on reducing the deficit — familiar territory for Panetta.

AMA leaders face congressional panel

AMA leaders faced a congressional panel in Washington recently, trying to head off a new round of cuts in Medicare.

"Whether it's for health reform or deficit reduction, the result in either case would be the destruction of Medicare as we and our patients know it," said AMA Executive Vice President James Todd, MD, speaking before the Physician Payment Review Commission. According to Dr. Todd, more cuts could leave Medicare paying just 34% of private payments by the year 2004.

According to the *New York Times*, two issues are likely to dominate the health policy agenda in this congress — curbing the growth of Medicare and Medicaid and proposals to give states more freedom to pursue their own health care plans. "These are only pieces of the national health care debate, but

REPUBLICAN "CONTRACT WITH AMERICA"

The Republican Contract with America is a package of 10 laws the GOP hopes to pass during the new congressional session. Following are contract provisions pertaining to health care.

New expenses

Senior Citizens' Fairness Act — Includes an incentive for private long-term care insurance
Cost: \$1.3 billion over five years

Proposed spending cuts

Reducing Medicare indirect medical education adjustment to 3% from 7.7%

Savings: \$13.5 billion over five years

Requiring managed care for Medicaid

Savings: \$10 billion over five years

Increasing Medicare Part B premiums for wealthy beneficiaries

Savings: \$7.4 billion over five years

Increasing Medicare Part A deductibles for wealthy beneficiaries

Savings: \$1.7 billion over five years

Requiring 20% co-insurance for Medicare clinical laboratory services

Savings: \$6.2 billion over five years

Source: *Modern Healthcare*

they are big pieces," the *Times* said.

With the collapse of the Clinton plan and all other federal efforts at reform, states are clamoring for more authority to tax and regulate health benefits provided by companies operating within their borders. Many states say they need relief from federal regulation such as ERISA to carry out plans to expand coverage and control costs.

A huge debate is expected over caps and cuts in Medicare and Medicaid, driven by a desire to reduce the federal budget deficit. Economic experts say there is no way to balance the budget and cut taxes unless there are huge reforms in entitlements. ■

AT A GLANCE

The AMA has proposed that its Hospital Medical Staff Section instead be called the Organized Medical Staff section.

The IMS has available cassette tapes of excellent presentations by consultants at the recent *Futures* conference "Organizing for Change". The presentations cover capitation, new physician arrangements and the future of managed care in Iowa. See page 10 for details on ordering.

The Congressional Budget Office estimates that medical technology and intensified use of existing technology will account for nearly half the growth in health care expenditures from 1995 to 2003. Many reform plans — including the Clinton Plan — did not address this problem, says US News and World Report.

Legislative Affairs

AT A GLANCE

The IMS will sponsor a Medicine Day at the Iowa Legislature for physicians, Alliance members and clinic managers Wednesday, March 22. This will be an opportunity to observe the Iowa Legislature in action. A briefing and luncheon will be held at the IMS prior to the trip to the capitol. For more information, call Paul Bishop at the IMS, 515/223-1401 or 800/747-3070.

Smoking by American adults has fallen to its lowest level since 1941, down to 26%. However, smoking among teenagers has held steady or increased. Since 1987, the smoking rate among high school seniors has been inching up.

Statewide, the number of motorcycle fatalities decreased 37.5% after introduction of California's helmet use law, from 523 fatalities in 1991 to 327 in 1992.

More legislative priorities approved

Based on the recommendations stemming from a late November meeting of the IMS Committee on Legislation, the IMS Board of Trustees has approved the following additional legislative priorities for this session:

Patient Protection Act (PPA)

The American Medical Association has developed model state legislation similar to the Patient Protection Act being advocated on the federal level. The IMS will work to implement elements of the PPA with private sector organizations offering managed care plans and may use elements of the PPA as a basis for discussion and negotiation throughout the legislative process.

Bicycle helmets for children

The IMS supports legislation to require children to wear protective helmets when riding bicycles.

Definition of a podiatrist

Iowa Podiatric Society is proposing legislation to redesignate podiatrists as "podiatric physicians". Because the Iowa Code already includes podiatrists under the definition of a physician, IMS opposes opening the code to further amendment.

Definition of surgery

IMS believes surgery should be performed only by individuals licensed to practice med-

CONTACTING YOUR LEGISLATORS

Telephone number during the session:

Senators 515/281-3371
Representatives 515/281-3221
Governor 515/281-5211

Write to them at:

STATEHOUSE
Des Moines, Iowa 50319

You may also contact your legislators at home when the legislature is not in session. If you don't know who your legislator is or need your legislator's home address and phone number, call Lyn Durante of the IMS staff, 800/747-3070 or 515/223-1401.

icine and surgery, or by those additional categories of practitioners already specifically licensed to perform surgical services. The IMS supports legislation to define surgery, including the use of lasers in performing surgical procedures.

Statewide trauma system

The IMS supports legislation establishing a statewide trauma care system as proposed by the Iowa Trauma Systems Development Project Planning Consortium. The Consortium includes representatives of the IMS and other physician organizations. The IMS will work to include representation by all appropriate physician specialties on councils and committees established by legislation. **IM**

IMS POSITION PAPERS AVAILABLE TO MEMBER PHYSICIANS

Position papers on a number of key health issues are available from the IMS public affairs staff. Call Lyn Durante at 515/223-1401 or 800/747-3070. Additional position papers may be drafted as issues arise during the session. Currently, papers are available on:

Managed Care, Any Willing Provider
 Definition of Surgery
 Tobacco Issues
 Lay Midwifery (available mid-January)

Liability Reform
 Organ Procurement
 Health System Reform

CHMIS
 Helmet Law
 Smoker's Rights

Medical Economics

CHMIS is coming July 1, 1996

Senate File 2069, approved and signed by Governor Terry Branstad on April 1, 1994, enables implementation of a statewide Community Health Management Information System (CHMIS) in Iowa.

This legislation mandates all health care providers to submit claims electronically and all payers to accept one uniform claim format. The CHMIS will also be used as a central data repository, storing all information submitted on the HCFA-1500 and UB-92 claim forms in the first phase of the initiative.

The IMS will present a complete overview of CHMIS activity in Iowa to groups of member physicians. Call Donna Bottorff at the IMS, 800/747-3070 for more information.

IFMC nominating slate

The Iowa Foundation for Medical Care (IFMC) Nominating Committee has announced its proposed slate for the upcoming board of directors election.

The IFMC planned to mail ballots early this month. Voting instructions will accompany the ballots.

IFMC members will be notified of election results by mail in mid-February.

All of the MD positions elected by members are for three-year terms.

Nominees for county representative director positions:

Michael Crane, MD (Cerro Gordo County)
Koert Smith, MD (Des Moines County)
Karl Larsen, MD (Johnson County)
Jolynn Glanzer, MD (Linn County)
Paul Karazija, MD (Polk County)
Peter Boesen, MD (Polk County)
Gary DeVoss, MD (Pottawattamie County)
Elie Saikaly, MD (Story County)

Nominees for area representative director positions:

John Ellis, MD, District Area 1 (Johnson, Muscatine, Scott, Washington, Louisa,

Jefferson, Henry, Des Moines, Van Buren and Lee).

Stephen Piercy, MD and Steven Sohn, MD, District Area II (Sac, Calhoun, Webster, Hamilton, Carroll, Greene, Boone, Story, Guthrie and Dallas).

For more information about the IFMC elections, contact William Vanderpool, IFMC vice president of corporate affairs, 515/223-2170.

In case you haven't heard . . .

HCFA has designated Iowa as a single Medicare payment locality with one fee schedule. The change began January 1.

The original request to be designated as a single locality came from an Iowa Medical Society House of Delegates action in 1992 and was spearheaded by a significant number of practicing physicians.

IMS has supported and coordinated Iowa's petition to HCFA because equal Medicare payments throughout all areas of the state could attract more physicians to rural Iowa.

Medicaid funding granted

As part of OBRA '94, the federal government directed state Medicaid agencies to pursue a physician based point-of-service claims processing system. The federal government will provide funding to Medicaid to enhance operations and make this possible.

The Department of Human Services and the Iowa Medical Society are studying the appropriate methodology to make this system usable for physicians. Physicians will need the following equipment:

- 1) a computer with a high speed modem;
- 2) an arrangement with a network;
- 3) software for transmitting and receiving data elements required on the HCFA-1500 form;
- 4) staff with computer skill.

Medicaid is currently in the process of

AT A GLANCE

Federal officials said medical inflation in 1993 was the lowest in seven years. HCFA says Americans spent an average of \$3,299 each on health care, \$205 more than 1992. This 7.8% increase was the lowest since 1986.

A study in JAMA says physicians could reduce chances of being sued for malpractice by not acting rushed or being impersonal.

New Jersey, which pays the third highest Medicaid rates in the nation, plans to cut by 20% the amount of money hospitals receive to care for Medicaid patients.

continued

Medical Economics

continued

designing the proposed system. Input from physician groups will be appreciated. Call Donna Bottorff at the IMS, 800/747-3070, for more information or to comment.

State health contract awarded again

Iowa welfare officials announced they will award a disputed \$100 million state contract for mental health management to a California firm that was runner-up last summer in competition for the state's business, according to a recent story in the *Des Moines Register*.

Last June, the state announced it had chosen Value Behavioral Health Inc. from among eight bidders for the mental health managed care contract.

Medco, the California firm which has now been awarded the contract, was runner-up in the bidding last summer but then filed a lawsuit alleging a flawed selection process. A Polk County judge found in favor of Medco, citing "overwhelming circumstantial evidence of impropriety". He ordered Value disqualified from bidding.

Don Herman, the Iowa Department of Human Services administrator in charge of the Medicaid program, said the mental health initiative will take place in September.

Less aggressive regulation

The *Kiplinger Newsletter* is predicting that federal regulators will be less aggressive because of the election.

"Republican-led congressional committees will lean hard on regulators to take it easy on rulemaking or risk losing a chunk of their budgets," said *Kiplinger*.

The government may drop a plan to hold employers responsible for making their drivers buckle up. Instead, employees will be held personally liable.

OSHA plans to propose new rules for repetitive motion injuries this year, but Congress will ask that small businesses be exempt and will demand proof that using computers can cause wrist injuries.

Physician, dentist federation in Florida

The Associated Press reported that a newly formed Federation of Physicians and Dentists in Brevard County, Florida plans to challenge antitrust laws prohibiting collective bargain-

ing by physicians. The group, which has 100 members, also plans a public relations campaign against what it calls restrictive rules and regulations.

"The AMA recognizes that managed care has both advantages and disadvantages," commented Nancy Dickey, MD, AMA vice chair. She said there are several physician groups who are "more activist than a traditional organization affords them."

Meanwhile, the Florida Medical Association's legal counsel advised the physicians to exercise extreme caution about joining "the union", warning that the FTC or Justice Department could step in if they try to bargain collectively.

Deere pushes up deadline

John Deere has sent a letter to all of its health care providers asking that claims be submitted electronically no later than January 1, 1995. In the letter, Deere officials said this will be a contractual requirement by January 1, 1996.


Provisions for implementation of CHMIS require that all physicians submit electronic claims by July 1, 1996.

Legal reforms proposed by Republicans

Republicans are expected to propose a number of legal reforms during the first 100 days of the congressional session, but quick action is unlikely, experts predict.

Among initiatives to be introduced are "loser pays" product liability and malpractice and punitive damage limits.

Trial lawyers and consumer groups will gear up to block action.

Meanwhile, 20 million civil lawsuits will continue to be filed each year in the U.S. 

Practice Management

1995 CPT update

The CPT 1995 Code Update and the CPT '95 books have been released. Because it is essential to have the most up-to-date CPT information, be sure to get the '95 book soon.

The information in the introduction and in the E & Management guidelines at the front of the book is invaluable. The guidelines under each of the six sections and numerous subsections should also be studied carefully.

There are significant changes in the preventive medicine services area:

Codes 99381-99397 can now be used for patients with chronic illnesses and problems. If there is an insignificant or trivial problem which does not require additional work, include it in the preventive code.

However, if an abnormality is encountered or a preexisting problem addressed in the process of performing this preventive medicine E/M service and if it is significant enough to require additional work, office/outpatient codes 99201-99215 should also be reported. Modifier 25 should be added to the office/outpatient code to indicate a significant E/M service was provided by the same physician on the same day as the preventive medicine service.

Codes 99281-99397 include counseling etc. which are provided at the time of the initial or periodic comprehensive preventive medicine examination.

Counseling codes 99401-99412 are to be used for counseling, etc. sessions provided at an encounter separate from the preventive medicine examination.

There are also significant changes in emergency department coding, cardiac catheterization procedures and physical medicine.

A comprehensive list of CPT revisions is found in the appendices of the CPT '95 books. Detailed code changes are provided in

numerical sequence in the "CPT Assistant", Volume 4, Issue 4—Winter, 1994, for a cost of \$21.25 for AMA members. Order from the AMA by calling 800/621-8335.

HCFA E & M Code documentation

Since the IMS Services E & M Coding seminars in November, there have been the following changes in the final guidelines:

1. Chief Complaint: strike out as indicated: The CC is a concise statement describing the symptoms, problems, condition, diagnosis, physician recommended return or other factor that is the reason for the encounter, ~~usually stated in the patient's words.~~

2. Past and/or Social History: change the first full paragraph to: For the categories of subsequent hospital care, follow-up inpatient consultations and subsequent nursing facility care, CPT requires only an "interval" history. It is not necessary to record information about the PFSH.

3. Documentation of Examination: delete the fifth documentation guideline: ~~When a pelvic or rectal examination in an adult is deferred, the reason(s) should be documented.~~

4. Amount and/or Complexity of Data to be Reviewed: modify the second documentation guidelines as indicated: The review of lab, radiology and/or other diagnostic tests should be documented. ~~A simple notation~~ An entry in a progress note such as "WBC elevated" or "chest x-ray unremarkable" is acceptable.

Watch for more guideline changes in next month's Practice Management section. 

AT A GLANCE

IMS members can now save more than ever when they ship as few as 10 letters or packages each month via Airborne Express. Members pay only \$8.75 for a standard eight-ounce overnight letter express when they send a minimum of 10 shipments monthly. Also, physicians can save even more when they deposit their shipments in the Airborne Drop Box, paying at most \$7.50 for an eight ounce overnight letter express. For more information on the new rate structure for IMS member physicians, call 1/800-MEMBERS. Mention you are a member of the IMS.

A new Iowa law requiring all employers to offer access to health insurance to all employees was scheduled to go into effect January 1, but as of press time, the state had not issued final regulations. Watch future issues of Iowa Medicine for more information.

PRACTICE MANAGEMENT WORKSHOPS FOR YOU

Because of the overwhelming response and requests for additional programs on the new HCFA E & M service documentation guidelines, we will present additional programs (including information on the CPT Update) in January at the following locations throughout Iowa: SPENCER, COUNCIL BLUFFS, DES MOINES, BURLINGTON, IOWA CITY, WATERLOO, OTTUMWA AND MARSHALLTOWN.

Watch for a mailing on the sites and dates. We are also available for local programs at your selected site. Please contact Mary Reinsmoen at IMS Services, 515/223-1401 or 800/728-5398 for additional information.

Practice Management

continued

MIDWEST MEDICAL INSURANCE COMPANY FOCUS ON RISK MANAGEMENT

Issues to consider when retiring or leaving a practice

Physicians contemplating retirement or a change in practice face many important issues. Two areas that demand close attention are the issues of patient abandonment and the handling of medical records.

- When retiring or leaving one practice for another, notify patients well in advance. The Iowa State Board of Medical Examiners recommends a minimum of 30 days' notification.

- Put a notice in the office and in a publication of general circulation. Include the date of the change in practice or closing and indicate that patients may have copies (always maintain originals) or their medical records transferred to the physician of their choice. Or, you may wish to identify

the location where copies may be obtained.

- Send a letter to active patients with the aforementioned information. Stress the importance of follow-up care. Include an authorization for the release of medical records.

- If retiring from practice, maintain original records indefinitely by using a storage facility, microfilm or caretaker to assume responsibility for the medical records. Identify the caretaker in your notice to patients.

For further information, contact Lori Atkinson, MMIC risk management coordinator, MMIC West Des Moines office, PO Box 65790, West Des Moines, 50265, 800/798-9870 or 515/223-1482.

Two issues that demand close attention are patient abandonment and handling of medical records.

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Newsmakers

Surplus or restorable equipment needed

Dear Editor:

During November I was privileged to participate in a program with an organization known as Doctors of the World. I was assigned to the province of Kosovo, the southernmost area of what was formerly Yugoslavia. The main agenda in the area is to facilitate the immunizations of 150,000 children—the programs had been suspended for several years due to philosophical differences between the two ethnic groups in the area. The second mission is to improve and treat tuberculosis which is rampant both for children and adults. These programs obviously require months, if not years, for a solution.

Infant mortality and tuberculosis rates are the highest in Europe. Enteric disease, dehydration and sepsis are aggravated by malnutrition and crowded living conditions. Shallow wells as a source of water where no sanitary facilities exist and very heavy smoking habits contribute to this poor quality of life.

I spent several days with village doctors who were fascinated with my otoscope and ophthalmoscope. As a result, I taught them what can be seen and diagnosed. They do not have any hope of buying anything like that in their lifetimes. Similarly, the Pulmonary Hospital in Pristina, the capitol of Kosovo, does not have a bronchoscope, even though several of the staff are listed as pulmonologists.

If any readers have access to surplus or restorable equipment such as described above, please write: Ms. Abbe Stoddard, Secretary, Doctors of the World, 625 Broadway, 2nd Floor, New York, New York 10012. The telephone number is 212/529-1556.

Your help to fellow doctors would be appreciated. It is great to live and practice medicine in America.—Robert McCool, MD, Clarion

Letter to the Editor

New members (as of September 1994)

Cedar Rapids

Mario Mota, MD, ophthalmology
Loren Mouw, MD, neurosurgery
Mathew Reid, DO, emergency medicine
George Walker, MD, emergency medicine
William Witcik, MD, cardiology

Chariton

Greg Cohen, DO, family practice

Cherokee

George Ide, DO, psychiatry

Columbus Junction

David Bedell, MD, family practice

Council Bluffs

Clifford Boese, MD, orthopaedic surgery
Chitrita Roy, MD, pediatrics


Davenport

Anis Ansari, MD, internal medicine/nephrology
Lisa Davis, MD, family practice
Randy Gripple, MD, orthopedics
James Hansen, MD, pulmonary diseases
Carolyn Martin, MD, obstetrics/gynecology
Joseph Martin, MD, orthopedic surgery
Thomas McKay, MD, urology
Michael Netzel, MD, allergy/immunology
Carlos Rodrigues, MD, obstetrics/gynecology
Richard Syfert, DO, obstetrics/gynecology

Decorah

Harold Amsbaugh, MD, anatomic/clinical pathology

Awards, appointments, etc.

Dr. Dale Roberson, Cedar Rapids, has been named a fellow of the American College of Radiology. Dr. Corrine Ganske, Des Moines, has been named associate director of the family practice residency program at Iowa Lutheran Hospital. 

AT A GLANCE

This special issue on domestic violence was initiated by the IMS Domestic Violence Task Force. Members include Drs. Rebecca Wiese, chairman, Deborah Reisen, Francis Garrity, Dale Wassmuth and Jan Bannister (IMS Alliance).

Dr. John Rhodes, Jr., Pocahontas family physician, is participating in the American Medical Association's study of the organized medicine federation.

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Action: Yohimbine blocks presynaptic alpha-2 adrenergic receptors. Its action on peripheral blood vessels resembles that of reserpine, though it is weaker and of short duration. Yohimbine's peripheral autonomic nervous system effect is to increase parasympathetic (cholinergic) and decrease sympathetic (adrenergic) activity. It is to be noted that in male sexual performance, erection is linked to cholinergic activity and to alpha-2 adrenergic blockade which may theoretically result in increased penile inflow, decreased penile outflow or both.

Yohimbine exerts a stimulating action on the mood and may increase anxiety. Such actions have not been adequately studied or related to dosage although they appear to require high doses of the drug. Yohimbine has a mild anti-diuretic action, probably via stimulation of hypothalamic centers and release of posterior pituitary hormone.

Reportedly, Yohimbine exerts no significant influence on cardiac stimulation and other effects mediated by B-adrenergic receptors, its effect on blood pressure, if any, would be to lower it; however no adequate studies are at hand to quantitate this effect in terms of Yohimbine dosage.

Indications: Yocon[®] is indicated as a sympatholytic and mydriatic. It may have activity as an aphrodisiac.

Contraindications: Renal diseases, and patient's sensitive to the drug. In view of the limited and inadequate information at hand, no precise tabulation can be offered of additional contraindications.

Warning: Generally, this drug is not proposed for use in females and certainly must not be used during pregnancy. Neither is this drug proposed for use in pediatric, geriatric or cardio-renal patients with gastric or duodenal ulcer history. Nor should it be used in conjunction with mood-modifying drugs such as antidepressants, or in psychiatric patients in general.

Adverse Reactions: Yohimbine readily penetrates the CNS and produces a complex pattern of responses in lower doses than required to produce peripheral a-adrenergic blockade. These include, anti-diuresis, a general picture of central excitation including elevation of blood pressure and heart rate, increased motor activity, irritability and tremor. Sweating, nausea and vomiting are common after parenteral administration of the drug.^{1,2} Also dizziness, headache, skin flushing reported when used orally.^{1,3}

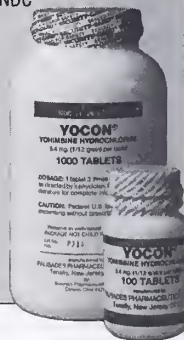
Dosage and Administration: Experimental dosage reported in treatment of erectile impotence.^{1,3,4} 1 tablet (5.4 mg) 3 times a day, to adult males taken orally. Occasional side effects reported with this dosage are nausea, dizziness or nervousness. In the event of side effects dosage to be reduced to 1/2 tablet 3 times a day, followed by gradual increases to 1 tablet 3 times a day. Reported therapy not more than 10 weeks.³

How Supplied: Oral tablets of Yocon[®] 1/12 gr. 5.4 mg in bottles of 100's NDC 53159-001-01 and 1000's NDC 53159-001-10.

References:

1. A. Morales et al., New England Journal of Medicine: 1221, November 12, 1981.
2. Goodman, Gilman — The Pharmacological basis of Therapeutics 6th ed., p. 176-188. McMillan December Rev. 1/85.
3. Weekly Urological Clinical letter, 27:2, July 4, 1983.
4. A. Morales et al., The Journal of Urology 128: 45-47, 1982.

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Break the silence, Begin the cure

Between January of 1990 and January of 1994, at least 30 Iowa women were murdered by their husbands or partners. Many more are battered each year and it is believed there are victims of domestic violence in the patient population of nearly every Iowa physician.

In May of 1994, the Iowa Medical Society Board of Trustees appointed an IMS Task Force on Domestic Violence. Though the O.J. Simpson case subsequently brought this issue to the forefront, the IMS Board was following the lead of current AMA President Robert McAfee, MD, who has made spouse/partner battering the focus issue of his presidency.

Seventy-five percent of partner battering victims seek treatment for immediate or long-term effects of abuse. However, physicians intervene in only 5-10% of suspected cases. Many survivors say they would have been more likely to discuss the abuse with their physician than anyone else.

Dr. McAfee believes physicians realize they could do more to help but don't have enough information to feel comfortable doing so. Perhaps physicians do not have an open avenue of communication with other professionals who might offer assistance.

The IMS Task Force on Domestic Violence, chaired by Rebecca Wiese, MD, a

Davenport family physician, decided physician education is the first responsibility of the IMS. Last fall, the task force recommended a comprehensive educational plan to be completed by April. Two special issues of *Iowa Medicine* are part of that plan. Other components are an educational videotape and accompanying handbook for physicians and posters, patient information pamphlets and hotline cards designed for distribution by physicians.

The logo for this project, seen on this month's cover, was designed by IMS Alliance President Barbara Bell. The bird breaking free of the granite block symbolizes victims of domestic violence breaking free of the tyranny of abuse.

On the following pages, you will find articles designed to raise your clinical knowledge of partner battering — information you can use to assist victims you encounter in your practice. There is an article on finding the right words to talk to patients about abuse. Articles by counselors explain why victims stay in abusive relationships and why batterers batter.

There is an interview with a survivor of domestic abuse who was nearly killed by her husband. In the scientific section, look for articles on the effects of domestic abuse on children and the root causes of violence.

Break
the
Silence



Begin the Cure

**"The doctor who
talked to me
so respectfully
doesn't know to
this day how much
he helped me."**

**DOMESTIC ABUSE
SURVIVOR**

COMING IN THE FEBRUARY ISSUE OF *IOWA MEDICINE*

- Domestic abuse intervention — what works, what doesn't work
- Special problems of battered women in rural Iowa
- Physicians' legal responsibilities, liability concerns

- Local resources for physicians, including an Iowa map of shelters
- Patient insert with a message from Laurie Schipper, executive director of the Iowa Coalition Against Domestic Violence

**Iowa Domestic
Abuse Hotline**

1/800-942-0333

**Iowa Coalition
Against Domestic
Violence**

515/281-7284

Finding the right words

Though most battered women eventually leave the abusive relationship, the process of leaving can take months or years. This can be frustrating for physicians who want to help their patients and don't understand why the woman seems to prefer living with her abuser. David Moen, MD, a physician practicing at the Fairview Riverside Emergency Department in Minneapolis explained it eloquently: "I saw these women as non-compliant patients. I told them to leave their situations, but they didn't do what I said. They didn't seem to want my help and it made me angry."

Then, a coworker was murdered by her husband and Dr. Moen saw partner battering in an entirely different light. He contacted a domestic violence shelter and set up a meeting with eight women staying there. He learned that most women don't admit abuse to physicians because they are either embarrassed or afraid of retribution if someone finds out.

"I learned not to let anger influence the care I give patients," Dr. Moen said. "The single most valuable piece of advice I have for physicians is not to feel you have failed if the woman denies she has been abused or returns home."

Dr. Moen believes that treating the victim with respect and dignity is the most important thing a physician can do and this opinion is validated by women who have survived domestic abuse. As one survivor put it, "Physicians have much more influence than they realize. With just a word or a phrase, you can give the woman the message that she doesn't deserve to be abused and that you respect her even though she has been abused. This plants a seed that may bear fruit later."

Experts in domestic abuse explain that victims feel trapped, embarrassed and afraid of their batterer. They feel responsible for the abuse and their self-esteem is lowered by repeated failed attempts to stop the violence. Keep in mind that most patients won't tell you they are being abused. You must ask.

High risk groups (patients who should be asked about domestic violence)

1. Pregnant women — 25-40% of women who are battered are battered during pregnancy. These women have twice the miscarriages of control groups and are four times more likely to deliver low birth weight babies.

2. Injured women in emergency departments — 20-35% of women with acute injuries in the emergency department have been hit. Highest risk injuries are to the face, neck, chest, abdomen and pelvis areas.

3. Suicide attempts — 24% of all suicide attempts are preceded by an episode of domestic abuse. Fifty percent of suicide attempts by black females are preceded by assault.

4. Depressed women — Approximately 25% of battered women report that at some time during their abusive relationship they were treated for depression.

5. Chemically-dependent women — Battered women are four times more likely to be chemically dependent.

NEXT MONTH
In the February *Iowa Medicine*, watch for a map of Iowa domestic abuse shelters and complete information on services offered locally around Iowa.



6. Women with insomnia, eating disorders, migraines, nonspecific pain — These could be signs a woman is living with the stress of an abusive relationship. These signs usually present in a primary care setting.

7. Women who repeatedly miss or cancel appointments — AMA President Robert McAfee, MD, suggests flagging a woman's chart if a male calls and cancels her appointment.

Questions and responses

Experts in domestic abuse recommend asking direct, simple questions if you suspect partner battering. Following are examples:

1. For patients with suspicious injuries

"That bruise looks painful. Did someone hit you?"

2. For depressed patients, suicide attempts or other complaints which raise red flags

"Sometimes people feel this way when someone in their life is trying to control what they say or do. Do you think this happens to you?"

3. What to say when the patient answers "no"

"I've seen people who are afraid or embarrassed to tell me they've been hit. I understand. I just want you to know that if you are ever hurt it's okay to tell me about it. This is a safe place to come and talk about it."

4. What to say when the patient answers "yes"

"I'm glad you told me. Sometimes people are afraid to talk about it. Are you in a relationship with this person?"

"You don't deserve to be treated this way. Getting out of these relationships isn't easy, but help is available."

It is also a good idea to ask if the patient feels safe going home, if she feels suicidal or if the abuser has a weapon. If the patient wants help, find out if she is aware of community support or would like you to call the domestic abuse hotline for Iowa (1/800-942-0333).

5. What to say if the patient appears offended

"I'm sorry, I didn't mean to offend you. I've seen many women with injuries such as this that are caused by hitting. Most women won't tell me unless I ask."

Physicians shouldn't try to do it alone

Partner battering is a complex problem and physicians should never feel they must solve it all alone in one patient visit. Domestic violence requires an interdisciplinary approach. Here are some tips from experts on making your office a physically and emotionally safe place for victims of abuse:

- Enlist coworkers to do this work with you.
- Educate all staff on domestic violence issues and local resources.
- Design a domestic abuse protocol for emergencies in your office.
- Develop a consulting relationship with your local shelter or intervention project.
- Display posters and pamphlets in your reception area and examination rooms.

**Physicians
should not feel
they have failed if
the woman denies
she has been
abused and
returns home.**

PHYSICIAN SURVEY
**Test your knowledge
of domestic abuse
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domestic abuse issues
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survey to the IMS
to help us determine
future educational
efforts.**

Violence begins subtly. This makes it difficult to identify the behaviors as they escalate and her fear increases.

Why do they stay?

In Iowa, between 20,000 and 44,000 women are abused in their homes each year. Domestic violence results in more injuries requiring treatment than rape, car accidents and muggings combined. Battered women are twice as likely to miscarry. The annual cost of treating domestic violence injuries in the U.S. is between \$5 and \$10 billion. Yet, only one in 25 battered women seeking treatment is identified as being abused.

Physicians are in a position to play an integral role in ending the cycle of violence. By becoming aware of the dynamics of domestic violence, they can help their patients seek appropriate assistance.

Often, the violence begins subtly. This makes it difficult to identify the behaviors as they escalate and her fear increases. Using coercion, threats, intimidation, emotional abuse, denying, blaming, isolation, economic abuse and the children as weapons, the abuser tears down her self-esteem. He has isolated her from family, friends and/or the community. He denies responsibility and treats her as subservient.

Battering is a conscious choice

Domestic violence is not a mental illness, nor is it caused by substance abuse — although this may intensify it. This is a conscious choice the batterer makes as a way to control another person because it is effective.

Battered women leave and return to the relationship an average of seven to nine times, and what they are actually doing is leaving the relationship in stages. She usually doesn't leave the first time because the violence is a new experience and he promises it will never happen again. As the violence escalates, she may leave for a few days or even weeks — for safety and to teach him a lesson. As the violence escalates further, he has established such fear in her that leaving may seem more dangerous than staying.

Statistics prove this feeling is justified — women face a 75% greater chance of being killed when they try to leave. Also, she may doubt her ability to provide for herself and her children. She may face poverty (50% of homeless people are battered women and their children). Religious beliefs may also be a factor keeping her in the marriage. Finally, since domestic violence is an ongoing pattern, the abuser has created constant barriers which prevent the victim from ending the relationship.

Look for stress-related symptoms

Due to the large number of battered women in Iowa, every woman who comes to you for care should be screened. Remember that when a battered woman comes in for medical treatment, it may be her way of reaching out for help.

If physicians look only for evidence of physical trauma, a majority of battered women will go unrecognized. Instead, look for stress-related symptoms such as the following:



KAY MAHER-SHARP

Ms. Maher-Sharp is a counselor at the Family Violence Center in Des Moines and coordinates the Center's First Responder program. This program is staffed by volunteers who are available to respond to victims of domestic violence 24 hours a day.



- chronic headaches
- depression
- substance abuse
- constant weight gain or loss
- shortness of breath
- insomnia
- suicide attempts
- gynecologic problems (frequent infections)
- chest pain
- injuries during pregnancy
- frequent visits with vague complaints

She's not non-compliant, she's afraid

Battered women are often viewed by physicians as non-compliant patients. It is important to remember that it may not be safe for her to disclose how she got her injuries or how she is being treated at home. She has been ordered by her partner not to talk about "personal matters" and has been conditioned that the abuse is her fault. Society's reaction to abused women often reinforces this conditioning.

Medical professionals are in a position to break through the patient's denial. Many women do not even realize they are being abused. Part of her survival mechanism may be to minimize the abuse and disassociate from her own body. She may not even be fully aware of all her injuries. You can help her recognize abusive behavior in the relationship and let her know you are concerned for her safety., Explain very specifically why you are concerned. When you question her about abuse, try to get an accurate picture of the violence.

Other important clues

Don't miss these other red flags that you may be facing an abused woman:

- She may "over explain" or justify herself.
- She may be very apologetic for taking your time.
- Her injury may be inconsistent with her explanation.
- Her partner may be demanding or overly protective.

It is extremely important for her safety to talk to her alone. There is little chance she will tell the truth or give any accurate information if her abuser is present. Physicians can use a variety of tactics to get the abuser out of the room, such as saying you wish to examine her in private or asking him to go and fill out patient information sheets.

Rather than beginning by asking about a particular injury, ask about the dynamics of her primary relationship. Talk to her in hypothetical "if/when" terms if she will not disclose the truth. Questions may include:

- "Are you ever afraid at home?"
- "Does your partner force you to have sex?"
- "Does your partner threaten you?"
- "Does your partner destroy your property?"

FEELINGS AND DEFENSES OF BATTERED WOMEN



By providing options in a sensitive, non-judgmental manner, you are laying the groundwork for battered women and their children to live free of violence.

“I’ve been bluffing all my life. Self-esteem? I had none.”

By normalizing her situation and not acting shocked by what you see or hear, the physician may help her recognize she is not alone and therefore feel safer in disclosing. By providing options in a sensitive, non-judgmental manner, you are laying the groundwork for battered women and their children to live free of violence. This also empowers victims of domestic violence to make the decisions that are best for them. Support her decisions and recognize that she is the expert in her own situation.

Documentation of your observations and the exact statements made by the patient is critical. This may be her only record of violence and may be very helpful for her in the future in custody or divorce proceedings.

There is no reason for physicians to be alone in helping abused patients. There are many local options for referral. In some communities, representatives for various domestic abuse projects are happy to come to your office or to the hospital to talk to the patient. Bringing the services to her may be the only opportunity to reach some patients.

There is no easy cure for domestic violence. Physicians are on the front lines in identifying victims. By advocating for battered women and providing them with as many options as possible, their ability to take steps toward becoming a survivor — rather than a victim — will be greatly enhanced.

In the time it took you to read this article, 100 women were abused across the U.S. Thank you for your willingness to learn how to become part of the solution.

A survivor's story

Editor's note: The names of the people mentioned in this article have been changed.

Linda's relationship with her husband began with flowers and compliments. It ended when he nearly beat her to death with a pool cue.

During the 12 years in between, Linda was manipulated, degraded, stalked and terrorized in a relationship that was stressful at best and nightmarish at worst. Friends and coworkers warned that John was going to hurt her, but she didn't — or couldn't — believe them.

“I've been bluffing all my life,” admits Linda, a tall, attractive woman with a matter-of-fact demeanor and no trace of self-pity in her voice. “Self-esteem? I had none.”

Raised in a home where she suffered long-term physical abuse at the hands of her stepfather, Linda became pregnant at age 16 and dropped out of high school to marry the child's father. Though her first husband didn't abuse her physically, she left him because he was emotionally abusive and a bad influence on their children.

Despite having two babies, she managed to earn her GED and graduate from LPN school. She met John — a nursing assistant — during new employee orientation at a Des Moines hospital. Though she had no wish to become involved, John — who Linda says could be “very charming” — wooed her with subtle persistence and eventually won her over.

“Even though you have some of the worst times of your life with an abuser, the thing that makes it hard is that you've also had some of the best times of your life with him,” she says.

Linda's relationship with her mother was already strained because of her mother's refusal to acknowledge her husband's abusive behavior toward Linda. When Linda married John — who is Black — her mother cut off all ties, leaving Linda with no family support.



**"I think the fact
I'm an RN worked
against me.
I guess people
assumed I had
control."**

Almost as soon as they were married, John began a campaign of brainwashing, put-downs and mind games. Despite the fact they had three children together, John worked only sporadically while Linda had two and sometimes three jobs.

"I was very good at nursing," she says with pride.

During one of her separations from John, she even managed to go back to school again and earn her RN. Meanwhile, John's behavior became more and more vicious. He became addicted to cocaine and slept with other women. He often chased her around the house, throwing objects such as coffee cups at her. Several times, she left him. Each time, he began stalking her and she would eventually go back to him.

"He followed me everywhere. One night, he loosened all the lugnuts on one of my tires. Another time, he beat my car with something and totally destroyed it," she relates. "Every time I looked out the window, he'd be there in his car watching me."

Throughout her second marriage, Linda's weight fluctuated wildly, a sign of the stress under which she was living. "I hated to come home from work," she recalls. "I never knew what I would find."

She went to a female physician who prescribed diet pills and tranquilizers but didn't ask about possible abuse. "I think the fact that I'm an RN worked against me. I guess people assumed I had control."

Linda gained almost no weight during her fourth pregnancy because she vomited constantly. Then, early in 1992, John hit her for the first time.

"I thought he'd broken my jaw. I'd always told him I could put up with everything else he dished out, but that I wouldn't tolerate it if he hit me. Do you redraw that line?"

Linda called the police and John went to jail. After that, Linda sought outside help to make her marriage work, including drug rehabilitation for John and couples counseling. Nothing helped. "I never told the truth to a counselor when John was there. I was too afraid."

Then, last May, John hit her son and Linda obtained a 'no contact' order from juvenile court. John left their home, which was across the alley from his mother. He began sleeping in his car in his mother's back yard so he could watch Linda. Linda's landlord refused to change her locks, so she wedged a knife in the door each night. Then, on July 1, she awoke at 6:30 a.m. and John was in her bed, choking her with a pool cue.

"He said 'I'm O.J. and I'm going to kill you'," she reveals. Using the pool cue as a bat, he beat her in the head, knees and throughout her body. At one point, her 10 year-old son came in the room. He eventually stopped beating her and left and a neighbor called for help.

Linda was hospitalized for three days with a severe concussion, head lacerations and other injuries; John was put in jail. He was charged with attempted murder and was unable to make bail. Six months later, she still has bruises and is suffering from crepitus on her knees. At the time of this interview, Linda had just learned that a judge dismissed the attempted murder charge against John, finding him guilty of willful injury.

"The judge said John chose to stop beating me, and that means he's not guilty of attempted murder," Linda says. "My doctor says he stopped because he wore himself out."

John will probably be out of jail in two years and Linda freely admits she is afraid of him.

"I don't think he'll forget about this by then. I think he'll be even angrier," she comments.

Linda offers this advice to physicians faced with victims of domestic abuse. "Ask specific questions but never judge. And never forget the shame women feel — it's very real. The last thing we need is someone giving us easy answers." ■

Who are the batterers?

It is estimated that between 85-95% of domestic violence perpetrators are male. Although some women are arrested and convicted of domestic assault, this article focuses on males as perpetrators and their intimate female partners as victims.

Domestic violence, or battering, is defined as a pattern of abusive behavior which includes physical assault, threats and intimidation, emotional abuse, sexual abuse and isolation of the victim. This expanded definition is important since society typically may excuse the assailant's violent behavior as a direct result of alcohol/drug use, "bad temper" or a response to the victim's behavior.

What often isn't recognized is that the violent incident is part of a pattern of behaviors designed to gain power and control over the partner. Many of these other behaviors, while not illegal, result in significant psychological damage to the partner and children.

Characteristics of batterers

Although abusive men come from a variety of backgrounds, races and occupations, there are common characteristics. Rigid sex role stereotypes are pervasive as abusive men attempt to place their partners in a submissive role. Because of the men's insecurity, jealousy and possessiveness are characteristics often manifested in interrogating and stalking behavior. Other characteristics include low self-esteem, emotional dependency on their partners, a history of violence in their family of origin and, most importantly, a perceived need to control their partners. These characteristics are based on their ingrained and unhealthy beliefs about men's and women's roles, intimate relationships and violence.

Those who abuse power are likely to justify behavior that keeps them in control and focuses attention away from themselves. The three most common obstacles that prevent men from taking responsibility for their abusive behavior are: blaming others, minimization and denial.

Often, violent men blame others (or something else) for their behavior. "She made me hit her" or "I hit her because I was drunk" are common excuses. Blaming is often used to reinforce his belief that his only option is to use force. The self-defense or retribution excuses ("I hit her so she would stop hitting me" or "She hit me first") fit in this category. By blaming his partner, he attempts to achieve three goals: 1) he presents himself as the 'good guy' and protects his positive image; 2) he shifts responsibility for his behavior, in other words, when she changes the abuse will stop; and 3) he avoids any guilt or shame that would make him feel bad about himself.

Minimization of the significance and effects of the abuse is another common response of batterers. Batterers may use words and phrases such as *only, just, merely, a little, hardly, barely, all I did was* and *she bruises easily*. What may be described by a batterer as "a poke in the chest" may in reality be a punch which caused a severe bruise. By minimizing abu-



DALE CHELL

Mr. Chell is the supervisor for Domestic Abuse Intervention Services, a program of Children and Families of Iowa. He also serves on the Iowa Department of Corrections Batterers' Committee.



Rigid sex role stereotypes are pervasive as abusive men attempt to place their partners in a submissive role.

sive behavior, one is able to justify it and trivialize the victim's injuries.

The most powerful reaction employed by batterers is denial. If there are no other witnesses to an assault, this excuse can be used because the burden of proof is on the accuser. The batterer can defend his position by attacking her position or credibility. If no other evidence can be produced except her injuries, he can claim he doesn't know what caused them or accuse her of injuring herself. This is the most difficult defense mechanism to break through, since it requires him to admit to something he completely denied before, consequently acknowledging he lied.

Most men who are abusive to their intimate partners are not violent to others. Abusive men are more likely to use controlling tactics against their partners where it might have the least chance of legal consequences.

What makes a relationship with a history of violence so much different from one in which disrespectful behaviors occur is the existence of fear for safety on the part of the victim. A physical assault often makes the other abusive behaviors much more threatening to victims who live in fear of being physically harmed. A slammed door in a relationship without fear for physical safety does not have the same impact it has in a relationship with a history of violence.

Intervention strategies for batterers

In July of 1991, Iowa law was strengthened regarding how the criminal justice system responds to domestic violence. One law mandates completion of a designated Batterer's Education Program (BEP) for defendants who are found or plead guilty to domestic assault. Over 30 BEPs have been established in Iowa to service a primarily male population.

Except in rare cases, violent and abusive behavior is learned. This means it can be unlearned. One goal of BEPs is to educate participants about the definition and identification of abusive behavior, use of time outs, alternative respectful behavior and negative consequences of abuse toward their partners, families and themselves.

BEPs follow standards of the Department of Corrections to maintain consistency, accountability and to achieve accreditation. All BEPs use a group format with male/female facilitator teams. The curriculum focuses on the participant's use of violence as a tool to gain power and control in a relationship. This structured group format is recommended because of the abuser's strong use of denial, blame and minimization. In order for participants to change, they first must admit their abusive behavior. The participant's denial of abusive behavior is often challenged by the group to help him become accountable for his behavior.

Other interventions

Conjoint therapy is not recommended for those in violent relationships. Although there may be "couples' issues" to work through, the violence is the perpetrator's issue and must be addressed first. There is a tendency in conjoint therapy to place responsibility on the

Batterers are proficient at “conning” the physician by acting the part of the concerned, solicitous husband.

dynamics of the relationship as the cause of violence. Often, abusive men are very willing to enter conjoint therapy because the responsibility for their violence can be shared.

Physicians need to be wary of referring to counseling services which have strong beliefs about traditional gender roles or which may encourage women to remain in a marriage at any cost. This intervention may endanger women by not adequately assessing for safety or by covertly supporting the abuse of power and control.

Individual counseling may be useful to abusive men and is often recommended for participants while attending the BEP group. Individual counseling, however, does not provide the structure and direction, nor does it allow for the valuable feedback a participant can gain from other group members.

Physician response

When physicians are treating victims for injuries caused by abusive partners, the primary goal should be safety for the victim. When an abusive man accompanies his female partner to the medical clinic or emergency room, he may show concern for her well-being and may insist on staying close during the examination. Often, he will provide reasons (it was “an accident” or “we were just messing around”) for her injuries. Batterers are proficient at “conning” the physician by acting the part of the concerned, solicitous husband.

Physicians should trust their instincts in helping them determine the causes of the patient’s injuries. It is a good idea to contact the local battered women’s shelter ahead of time to learn what assistance is available for treating patients injured by their partners. If abuse is suspected, physicians should treat and question the patient separately from her partner in order to more accurately assess her safety. Important questions include: “Do you feel afraid of your partner?” “What happens when you and your partner argue?”

Conclusion

Since 1990, 39 Iowa women have been killed by their current or ex-partners. They are survived by 54 children. When children from a violent home grow up, they carry the techniques they learned from their family of origin. Breaking this cycle of violence will require a cooperative effort by professionals from many disciplines.

IOWA PROGRAMS FOR ABUSIVE MEN

Contact the Batterer’s Education Program representative in in the following cities for locations of the 30 Iowa programs serving abusive men.

1. Waterloo	Bea Merritt	319/291-2091	5. Des Moines	Ken Smid	515/242-6924
2. Ames	Linda Murken	515/232-1511	6. Cedar Rapids	Jean Kuehl	319/398-3675
3. Sioux City	Jeff Page	712/252-0590	7. Davenport	Traci Bray	319/322-7986
4. Council Bluffs	Mike Hahn	712/325-0285	8. Ottumwa	Barb Macy	515/682-3069

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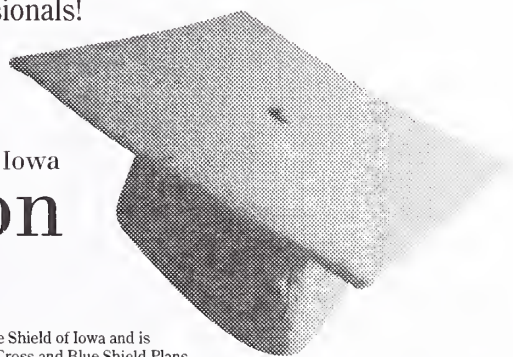
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The Journal

of the Iowa Medical Society

A child's perspective on abuse of a parent, by a parent

● DONNER DEWDNEY, MD

Violence in our society has reached epidemic proportions. Domestic violence between parents is psychologically destructive to children. Whether expressed physically or psychologically, violence at home is frightening to children. Frequently, violence and anger are confused and it is important to differentiate between the two. Parents should help children understand that anger is a normal and healthy human emotion that helps us define our boundaries and set limits, that people can be angry with each other without resorting to violence.

Parents more prone to be victims or perpetrators of domestic abuse typically have problems with self-esteem. Parents with a low self-esteem have trouble maintaining consistent and healthy self concepts. They become unpredictable with each other and their children. A friendly teasing remark by a spouse may be mistaken as a personal insult by the aggrieved partner, who may lash out angrily and violently.

A child's perspective on anger

The appearance of violence and cruelty changes the child's perspective on anger. It threatens the child's sense of safety as well as provokes fears in the child for the safety of his parents. When physical violence occurs, it results in a dramatic increase in the child's fears. Although physical abuse is characteristically initiated by males, physical abuse by wives of their husbands has increased over the past 10 years.

A child who watches a parent being injured frequently develops symptoms typical of depression, i.e., crying spells and regressive symptoms such as bed wetting, thumb sucking and withdrawal. A child who witness-

es the abuse of a parent over the long term frequently develops problems with loyalty, initially aligning themselves with the abused parent and later identifying with the abuser. Sadly, such children may take the position that daddy beat up mommy because "mommy deserves it."

Over time, these children develop definite personality changes, become preoccupied and inattentive at school and may develop secondary behavioral problems. For many of these children, the expression of anger in any form becomes forbidden because of their fear that it might explode into the rage and the violence that the child has witnessed at home.

Begins as a defense strategy

A common side effect of chronic domestic violence in the home is development of abusive behavior by the child. This behavior may begin as a defense strategy. The child cannot wait passively each time to be a victim of violence but instead he tries to control the situation by becoming violent first. Often this predatory behavior is directed towards smaller, helpless siblings and playmates. This defense strategy called "identification with the aggressor" allows the victim to become the perpetrator.¹ An example of this could be seen in the 1970s case of newspaper heiress Patricia Hearst, where there was a transformation of Patricia Hearst the kidnap victim to Patricia Hearst the bank robber.

Another side effect of domestic violence in children is a problem with sleeping. Sleep disorders are a frequent symptom of depression in these children and may also represent the fact that most violent arguments break out between their parents at night.

The treatment of children as victims of

The IMS Education Fund has designated this article as the Henry Albert Scientific Presentation Award for January 1995.

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A child's perspective on abuse of a parent, by a parent

continued

domestic violence and abuse is a lifelong challenge. A key step in the foundation of any treatment program is establishment of a safe environment for the child. Although temporary shelter care removes the immediate threat of physical danger, the children continue to require reassurance and support by caregivers that they will be safe. This is true whether the children are returned home or whether they are placed in residential treatment.

Divorcing the abusive parent may not bring relief to the child who often has to deal with the additional trauma of a broken family. Dr. Wallersteins' research suggests that 70% of children whose families divorce because of physical violence and abuse wanted their original parents to reunite when interviewed by the research group five or 10 years after the breakup.² This strong wish was expressed in spite of the obvious safer and calmer environments in the children's new transitional homes.

Children feel responsible

Children need help understanding that they are not the cause of their parents' arguments and beatings. Children feel responsible and blame themselves for arguments which may have focused on disagreements about parenting and on the child's behavior.

Children need to spend time with parents and caretakers who love them and whose behavior, not just words, establishes and confirms the promise of protection. Often children who are victims of domestic abuse are so traumatized that they require outpatient therapy and, in some instances, referral for long-term residential care.

These children struggle with explosive tempers and a pervasive distrust of grownups and authority figures. Treatment is focused on providing a safe environment and developing rules and safeguards that teach them how to manage their anger without resorting to violence against others or harmful behavior directed toward themselves.

Finally, the recovery of these children is dependent on the parents' ability to change their living patterns and resolve their problems with violence. There is a definite need in our domestic courts to enforce severe penalties for partner abuse with mandatory

sentencing and counseling when appropriate.

Our primary problem with violent behavior by children is directly related to how our children experience violence in the home—not just in the streets. Our final responsibility to children is to reinforce appropriate and safe parenting. **IM**

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Understanding domestic violence

● **TRUCE ORDOÑA, MD**

Because I am human, and I have accepted that humanness, nothing human ever shocks me—for I am capable of everything that is human.

Terrence, 400 BC, slave/philosopher

Setting the stage

If Shakespeare is correct in his assertion that life is a stage, physicians must understand the perceptual styles of every “player” in the domestic violence drama in order to understand it.

Domestic violence is defined as any volitional (direct or indirect, verbal and/or non-verbal) assaultive communication repertoire aimed at establishing and reinforcing power dominance over another person involved with him or her in an intimate, sexual, theoretically peer relationship.

This all-encompassing definition subsumes behavioral nuances wherein power can be expressed even in subtle innuendoes of control. An example is directing slams or manifestoes at the driver of another car or a character on television, a newspaper or an absent person which serve as “in-around” ways of communicating power games to the significant other. For instance, making joking or critical comments which generalize all women.

Such “repertoires” are behavioral patterns that have a particular set of features and which are used consistently because of assumed predictable responses from others. Their sub-components are: 1) Motor-acts; 2) emotional components—feelings and 3) cognitive components—expectations and attributions (what or who are perceived to be the “triggers” for such repertoires).

Origins

The two fundamental types of aggression

involved in domestic violence are “hands on” where there is actual violent touching or hitting and “hands off” where the perpetrator has no contact with the victim’s body. The violence is expressed through psychological battering and the destruction of pets or property.

Both types of aggression send the clear signal that the victim has no boundaries that protect him or her from the other.

The three major determinants of aggression are the origins of aggression, the instigators of aggression and the maintaining conditions.

The origins of aggression are: 1) Biological factors, 2) observational learning, 3) reinforced performance, 4) necessary instigator’s presence and 5) presence of regulators of such behavior.

In Central America, two Indian tribes dramatically present us with contrasting opposites in terms of aggression. The Tarahumares have, for centuries, outlawed any form of aggression by removing all violent words from their language. Domestic violence, murder and child abuse are literally nonexistent. The Yano-mamos, on the other hand, glorify violence. Their language and their handling of their women and children are replete with violence. Yanomamo women display the scars inflicted on them by their men as badges of honor.

The Tasadays in the Philippines have no words for “hate,” “anger” and “cruelty.” Fortune (1987) describes how the Tlingit people, who are native to southeast Alaska, define wife beating as a serious crime against the community because all members of the community are highly valued and necessary for tribal survival. In a rare case of wife beating, the whole community came together for a potlatch. They made the abuser’s clan make restitution to the victim’s clan in material goods. Making such

TRUCE ORDOÑA, MD
Dr. Ordoña practices adult and child psychiatry in Davenport.

Understanding domestic violence

continued

an act highly visible and expensive to the batterer deterred future incidents.

Exonerative moral reasoning

There are seven common methods used by batterers to neutralize self-condemnation of their aggression:

- Justification of higher principles—"The Bible says I am the head of my household. My wife must submit."
- Palliative comparison—"I am not a real batterer because I never used a weapon."
- Displacement of responsibility—"I was too drunk, I didn't know what I was doing." "She knows how to push my buttons."
- Diffusion of responsibility—"It happens in every marriage."
- Dehumanizing the victims—"She deserves everything I dish out."
- Attribution of blame to victims—"She drove me to it."
- Minimization and selective memory—"I got mad at her only once."

A person's repeated use of violence depends on: 1) appropriate inducements (instigators of aggression); 2) functional value (Does it serve a function? Does one get what one wants by being violent?) and 3) reward or absence of punishment.

The family, peers and the symbolic modeling of the media teach and exonerate violence in the following ways:

- Explicit demonstration of an aggressive style of conflict resolution.
- A decrease in normal restraints over aggressive behavior.
- Desensitization and habituation to violence.
- A shaping of expectations.

Instigators of aggression

There are three types of triggers of aggression: 1) Aversive instigators: to remove a perceived obnoxious or irritating stimulus; 2) incentive (inducement) instigators: to gain an anticipated payoff and 3) delusional instigators: bizarre belief systems.

Aversive and incentive instigators activate a variety of learned responses such as dependency, achievement, withdrawal, psychosomatization, self-anesthetization with drugs or

alcohol, constructive problem solving or aggression.

A person's course of action depends partly upon his acquired cognitive appraisal of the event (specifically whether he thinks the events can be controlled) and the model of response he has learned to use with such events. Sex role socialization contributes here. O.J. Simpson was abandoned by his father before he was born, raised in San Francisco's Potrero housing projects by an absent mother in a violent, dyssocial environment and accorded celebrity status for knocking people over in football. In addition, there were no real consequences for thirteen 911 calls involving blatant spousal battering.


Maintaining conditions of aggression

The consequences (either rewards or punishments) determine whether aggression continues, becomes regulated or stops. There are three types of rewards: 1) Tangible ones such as establishing control in male-female relationships, the expression of emotional arousal (anger, anxiety, fear, frustration or sadness) or getting what is wanted in a particular incident; 2) social status from acting in accordance with sex role standards or from specific rewards from peers and 3) alleviation of the perceived aversive stimulus as the victim tries to accommodate the perpetrator to survive the abuse.

The rewards are most reinforcing if they are characteristically unpredictable and inconsistent.

External punishments as regulators are effective only when the benefits derived from the aggression are considered and the nature, severity, timing and likelihood of the punishment are appropriate.

Domestic violence is a community problem. This concept runs counter to the rabid love affair we have with individualism in this country. Unless we act as an interdisciplinary team, we can never solve this problem. We should attack this problem by aiming for integration from design rather than falling into eclecticism by default.

All approaches, regardless of name, should first and foremost aim at safety for both the victim and the perpetrator. For either of them to be in rigor mortis would make all intervention akin to securing the barn door long after the mules have gone. 

A world of violence

Our society faces a problem of monumental proportions—violence. Violence is symptomatic of a deep social, political and economic disease within our society. For more than 100 years, we have understood that the drive toward aggression is a basic component of the human psyche. Children live in a world of violent acts by adults. Adults promote games of violence and present television programs that further expose children to violence. It has been estimated that TV programs and commercials show an act of violence or use a spoken word of violence every 15 seconds. Parents further accentuate this atmosphere at sporting events by urging the youthful athletes to “hit him; kill him.” A common expression of desire for an object is “I would kill for one of those!”

Data indicates that 90% of parents hit toddlers; more than 50% continue this practice into the teenage years. Violence is spoken, seen and breathed . . . and seemingly loved. Setting aside the numerous forms of violence for the moment, this issue of *Iowa Medicine* addresses the stigma of domestic violence. Studies show the knowledge level of physicians concerning family violence and their skills concerning intervention is varied and not well defined.

About four million American women are physically abused by their husbands or boyfriends each year; domestic violence affects one of four women. Domestic violence is esti-

mated to cost the United States \$5-10 billion a year in health care costs, lost productivity and criminal justice intervention. Other statistics are equally shocking. As many as 35% of women who visit hospital emergency rooms are seeking treatment for symptoms related to ongoing abuse, but only 5-10% of domestic violence is recognized. How many women seen in physician offices/clinics for “injuries” are recognized as victims of violence is uncertain.

Recognition and reporting of child abuse has improved because of the legal implications for anyone knowledgeable of such; not so for violence against women. A prevailing question concerning these battered women is “Why do they tolerate abuse?” Is it fear of isolation, i.e. no where to go in security or fear of retribution

Perhaps a better question is: “Why does society tolerate batterers?”

from the batterer? Perhaps a better question is “why does society tolerate batterers?” The problem has no boundaries; though poverty accentuates the problem, we see this social stigma among rich and poor, urban and rural.

Many groups, notably the AMA, have inaugurated programs to combat domestic violence. Citizens must be made aware of the prevalence of violence and become involved. Physicians must recognize the victims and become involved. This is a social problem and no person should be excused from exercising social responsibility for those who are abused. **IM**



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Healing diversions

A hospital architect, with talent also as a sculptor, once remarked that his attention to the colors and designs painted on the walls, just as to many other environmental details, served not only general utility, but contributed to a "healing environment". He said he often has trouble persuading "hard-headed skeptics" that the environment makes any real difference to the task of getting well. Those skeptics had not been adequately schooled, he said, to understand that not all things that count can be counted.

That conversation returned to me today when, glancing through a profusely illustrated history of medicine, I saw a splendid colored photograph of the remarkably intact amphitheatre neighboring the famous Aesculapian Temple at Epidaurus, Greece. There still stands the impressive outdoor arena, adjacent to the pavilion where the sick sought soothing, healing sleep. This edifice, seating 14,000, was a place devoted to the drama, dance, song or poetical recitations of the day. There can be little doubt, from the architecture plus collateral evidence, that such entertainments were deemed therapeutic.

That all but the most intense pain and suffering can be allayed through diversion and distraction seems clear enough: have we not installed television in almost all hospital and nursing home rooms? Such stimulation, even if violent or melancholy, seems to block at least temporarily the awareness of other distress.

The pain of needles entering and gyrating in the skin (acupuncture) or electrical shocks (TENS) prompts the explanatory hypothesis of the "neurological gatekeeper". May we not watch a video performance of Hamlet, ballet, a juggler or Roseanne, listen to a strolling group of carolers in the corridor, chat or play cards with a visitor—and feel less of what misery ails us? Are these not also gatekeepers?

Some of us may resist asserting that pleasing colors, designs or art objects on the walls can be similarly diverting or healing. Because we may respond to the visual arts both cognitively and emotionally, I wonder whether these complex events deserve to be called right-brain or left, but that datum isn't what matters most.

I cannot accept Norman Cousins' well-publicized claim that his watching and laughing at Marx Brothers films each day was indeed what healed—even cured—his alleged collagen vascular disease. Neither do I find reason to reject what we know of biology, pathophysiology or therapeutics in order to grant the potential usefulness of entertainments and placebos of diverse types. Eventually we will learn to explain better the biochemical events that underlie such clinical observations.

Of course we should seek to cure when that may be possible, but in all circumstances we must strive to make the patient feel better. That was surely Aesculapius' strong suit. My architect friend is of that lineage and so, it seems, am I. I hope you are, too. **IM**

**There can
be little
doubt such
entertainments
were deemed
therapeutic.**



RICHARD CAPLAN, MD

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Exceptional opportunity for primary care trained or experienced emergency physician. Ottumwa Regional Health Center is a 275-bed facility serving an 8 county area in SE Iowa and NE Missouri. 21,000 volume/12 and 16 hour shifts with double coverage at peak times. Excellent medical backup is provided by a medical staff of 50 physicians representing a broad range of specialties. Rathbun Lake, a beautiful 11,000 acre lake, is 40 miles from Ottumwa and offers an abundance of recreational activities. Mid-western hospitality, safe living and award winning schools make Ottumwa a place to call "home." Guaranteed minimum compensation package including paid malpractice. **Send CV or call Sheila Jorgensen, Emergency Practice Associates, P.O. Box 1260, Waterloo, Iowa 50704; 800/458-5003.**

Mankato Clinic, Ltd.—A progressive group practice is seeking additional BE/BC physicians in the following specialties: family practice, invasive cardiology, oncology/hematology, orthopedic surgery and general internal medicine practice. The Mankato Clinic is a 65-doctor multispecialty group practice in south central Minnesota with a trade area population of +250,000. Guaranteed salary first year, incentive thereafter with full range of benefits and liberal time off. For more information, call Roger Greenwald, Executive Vice President, at 507/389-8500 or Anthony C. Jaspers, President, at 507/726-2136 or write 1230 East Main Street, P.O. Box 8674, Mankato, Minnesota 56002-8674.

Marshalltown, Iowa

Best of both worlds—rural small group atmosphere, urban large group amenities. Seeking quality emergency physicians interested in stellar emergency medicine practice. Full-time and regular part-time. 12K volume/12-hour shifts. Democratic group, highly competitive compensation, paid St. Paul malpractice with unlimited tail, excellent benefit package/bonuses for full-time. Numerous other Iowa locales. **ACUTE CARE, INC., P.O. Box 515, Ankeny, Iowa 50021; 800/729-7813 or 515/964-2772.**

Internal Medicine and OB/GYN Practice Opportunities—Rural lake country community is seeking the above practitioners to join an active 12 (soon to be 14) physician multispecialty group. Quality, comfortable living environment, multiple recreational activities, fine educational opportunities and cultural activities abound. Opportunity includes relaxed call, liberal salary and exceptional benefits. Send curriculum vitae or inquires to Lake Region Clinic, PC, Attention: Joel Rotvold, PO Box 1100, Devils Lake, North Dakota 58301 or call 800/648-8898 for further information.

Locum Tenens Emergency Medicine

Seeking quality physicians interested in emergency medicine practice or primary care locum tenens. Full-time and regular part-time. Numerous Iowa locales. Democratic group, highly competitive compensation, paid St. Paul malpractice with unlimited tail, excellent benefit package/bonuses to full-time physicians. Contact **ACUTE CARE, INC., P.O. Box 515, Ankeny, Iowa 50021. Phone 1-800/729-7813 or 515/964-2772.**

Family Practice Physician—Rare opportunity for a BE/BC family practice physician to join an established, progressive 8-physician practice in Marshalltown, Iowa, a thriving family oriented community 40 miles northeast of Des Moines. We have a beautiful new facility, a qualified staff and enjoy a supportive relationship with our 176-bed local hospital. Our philosophy is to provide personal, quality care to each of our patients, while maintaining our productivity, profitability and efficiency. This position offers an excellent benefit package, a voice in decision-making, 1 in 8 call and a very competitive salary/dividend package. For more information call or write to Michael Miriovsky, MD or James Burke, MD, Center for Family Medicine, PLC, 312 E. Main Street, Marshalltown, Iowa 50158 or call 515/752-5469.

General Surgeon, Creston, Iowa—An opening for a third BC/BE surgeon in a very busy general surgery practice located 1 hour from Des Moines, Iowa. Two-surgeon department, expanding to 3 due to work load, is associated with 13 other physicians. Salary and benefit package very lucrative including moving expenses and full partnership within 1 to 2 years with limited call duty. Country living in a community of 9,000 with excellent educational system, recreation, low crime rate and lifestyle not found in metro areas. Contact Mike Brentnall, 515/782-2131 or send CV to Creston Medical Clinic, PC, 526 New York Avenue, Creston, Iowa 50801.

Chief Surgical Service/Residency Program Director—The Department of Veterans Affairs Medical Center, Des Moines, Iowa, invites applications for Residency Program Director and Chief, Surgical Service. The VAMC is a 153-bed acute medical surgical hospital with a large multispecialty outpatient program. The General Surgical Residency program recently was fully accredited by the ACGME. Applicants should be academically oriented with administrative abilities and experience in postgraduate medical education. In addition, they should be Board Certified in general surgery. Regular hours, liberal fringe benefits and a competitive salary. Des Moines combines the advantages of midwestern small town family living with the cultural amenities of an urban center. This city is particularly noted for the excellence of its public and parochial school systems. Submit CV to the Chief of Staff, VAMC, 3600 35th Street, Des Moines, Iowa 50310, 515/271-5853. EOE.

Family Practice Northeast Iowa

Seeking quality primary care physician interested in family practice locum tenens opportunity with potential for full-time appointment. Monday through Friday 9 a.m. to 5 p.m. Shared town call. No OB. Highly competitive compensation. Paid St. Paul malpractice with unlimited tail. Excellent benefit package/bonuses. Please contact Melissa Milliken, **ACUTE CARE, INC., PO Box 515, Ankeny, Iowa 50021. Phone 800/729-7813 or 515/964-2772.**

Emergency Medicine Fort Dodge, Iowa

Immediate opportunity for primary care trained or experienced emergency physician. Trinity Regional Hospital is a 200-bed facility acting as a regional referral center for northwest Iowa. 15,000 annual volume/24-hour shifts. Medical backup is diverse with a full range of specialists represented. Ft. Dodge, a community of 26,000 nestled in the beautiful Des Moines River valley, is the commercial hub of north central Iowa. Ft. Dodge provides a warm friendly community in which to live and raise a family. An outstanding compensation package includes health/dental, life, disability, malpractice insurances. Send CV or call Sheila Jorgensen, Emergency Practice Associates, P.O. Box 1260, Waterloo, Iowa 50704; 800/458-5003.

Internal Medicine, Carroll, Iowa—Outstanding professional opportunity for an internal medicine physician in a progressive, safe and clean community of 10,000. This opportunity is available for either practicing internal medicine physician, or the internal medicine physician just beginning practice. Excellent schools (Catholic and public), quality hospital and significant income potential available. For more information, call Randy Simmons, vice president, at 1-800/382-4197 or write St. Anthony Regional Hospital, South Clark Street, Carroll, Iowa 51401.

Emergency Medicine, Medical Director, Keokuk, Iowa—Outstanding opportunity for a career-minded primary care or experienced emergency medicine physician. Keokuk Area Hospital is a 112-bed facility serving SE Iowa, NE Missouri and western Illinois. 10,000 annual volume with a staff of 24 physicians representing major specialties. Remuneration package in excess of \$140,000 plus employee benefits. Call Holly Stanwich at 800/326-2782 or fax your CV in confidence to 314/291-5152.

Boone, Iowa

Seeking a quality emergency physician interested in a stellar emergency medicine practice. Full and regular part-time position available. Democratic group, paid St. Paul malpractice with unlimited tail. Excellent benefit package/bonuses to full-time physicians. Average volume with above-average compensation. **ACUTE CARE, INC.**, P.O. Box 515, Ankeny, Iowa 50021; phone 800/729-7813.

Family Practice, Fairfield, Iowa—Over \$140,000 package for the first year. Three board certified family physicians and physician assistant seeking 1 to 2 family physicians to join them. Progressive town of 10,000 in southeast Iowa. Recent large addition to clinic building. Seven million dollar addition remodeling of the hospital. Moving costs, student loan repayment, excellent salary, pension and benefits offered with no building buy-in required. Contact Fairfield Clinic, 304 South Maple Street, Fairfield, Iowa 52556; 515/472-4141.

LeMars, Iowa

Seeking quality physicians to practice at a 4300 average volume ER. Director and staff positions. Full and regular part-time. Democratic group, highly competitive compensation, paid St. Paul malpractice with unlimited tail, excellent benefit package/bonuses to full-time physicians. **ACUTE CARE, INC.**, P.O. Box 515, Ankeny, Iowa 50021; phone 800/729-7813.

Family Practitioner—McFarland Clinic is actively recruiting a BE/BC family practice physician to assume the responsibilities of an established family medicine practice in central Iowa. Practitioner has support of over 80 medical and surgical sub-specialty physicians in same multispecialty group. Full privileges for a residency-trained family physician at Mary Greeley Medical Center, a 200-bed hospital in Ames, Iowa. Night call on a rotating basis at the Emergency Room at MGMC. McFarland Clinic offers distinct advantages for the practicing physician in providing excellent compensation and benefits, practice management services and a generous retirement program, all in an environment which emphasizes physician cooperation and teamwork. For additional information, call or submit CV to Karen Andersen, 515/239-4535, McFarland Clinic, P.C., 1215 Duff Avenue, Ames, Iowa 50010.

Emergency Medicine, Council Bluffs, Iowa—Opening available for qualified physician to join group of emergency physicians. Training and/or certification in primary care specialty or emergency medicine. Flexible scheduling. Newly remodeled emergency department. Enjoy rural and urban atmosphere. Compensation up to \$200K/year plus vacation. Write Bluffs Emergency Care Services, PC, 933 East Pierce Street, Council Bluffs, Iowa 51503; 712/328-6111.

Emergency Medicine Burlington, Iowa

Outstanding opportunity in emergency medicine for primary care trained or experienced emergency physician. Burlington Medical Center is a 239-bed facility serving a multi-county area in SE Iowa, NE Missouri and western Illinois. 19,000 volume/double coverage at peak times. BMC medical staff consists of 80 physicians representing a broad range of specialties. Burlington, a community of 30,000, sits on the banks of the Mississippi River with commanding river views giving way to wide open horizons. Cultural opportunities take many forms from art and history museums to Mississippi River festivals and SE Iowa Symphony Orchestra to the Iowa state chili cook-off. Iowa's reputation for quality education is reflected in the Burlington schools. Burlington is a community where balance between family and career is easy to maintain. Guaranteed minimum compensation package including paid malpractice. **Send CV or call Sheila Jorgensen, Emergency Practice Associates, P.O. Box 1260, Waterloo, Iowa 50704; 800/458-5003.**

Family Practice, Carroll, Iowa—Outstanding professional opportunity for family practice physicians in a progressive, safe and clean community of 10,000. These opportunities are available for either experienced family practice physicians, or the family practice physician just beginning practice. Excellent schools (Catholic and public), quality hospital and significant income potential available. For more information, call Randy Simmons, Vice President, at 1-800/382-4197 or write St. Anthony Regional Hospital, South Clark Street, Carroll, Iowa 51401.

(Continued next page)

Advertising Rates and Data

Regular classified advertising sells for \$2.00 per line with a \$30 minimum per insertion. For members of the Iowa Medical Society the rate is \$20 per insertion. Display classified advertising sells for \$25 per column inch, per month. Sizes range from 1 column by 2 inches to 1 column by 6 inches. A variety of type sizes, borders, reverses or screens can be included in the ad. Blind box numbers are available upon request at no additional charge. Copy deadline is the 1st of the month preceding publication. Send or fax copy to Iowa Medicine, 1001 Grand Avenue, West Des Moines, Iowa 50265-3599, fax 515/223-8420.

Sioux City—An excellent position is available for a BC/BE family practice physician in a new community health center. A full range of family practice medicine is needed in a community that is very supportive of the center. Sioux City is a great place to raise a family and has excellent public and parochial school systems, a community college, 2 liberal arts colleges, a graduate center, 2 excellent medical centers, a Residency Training Program (family practice), etc. The center offers a competitive compensation and benefit package, paid malpractice, etc. **FEDERAL LOAN REPAYMENT PROGRAM AVAILABLE.** For more information write Jeff Hackett, Executive Director, Siouxland Community Health Center, 1709 Pierce Street, Sioux City, Iowa 51105 or call 712/252-2477.

Emergency Medicine, Des Moines, Iowa—Opportunity to join an established emergency medicine practice at Iowa Lutheran, member of the Iowa Health System. BE/BC in emergency medicine or primary care specialty with experience. Call me to learn more about our department and generous compensation package. Contact Larry J. Baker, DO, FACEP, 700 E. University, Des Moines, Iowa 50316; 515/263-5263.

General Faculty, Department of Family Practice, University of Iowa College of Medicine—The University of Iowa Department of Family Practice offers full-time faculty positions for residency-trained, ABFP certified family physicians. Obstetric skills and previous teaching experience highly desirable. Additional faculty needed to address new primary care initiatives. As a part of a full academic department, responsibilities include teaching, research and patient care. Well-established, 24-resident program is university-administered, community-based, and has admissions at community and university hospitals. A new model office facility is being built. Well-established department with special strengths in its clinical and behavioral science faculty. As a "Big Ten" university community, Iowa City is a great place to live. Appointment and salary commensurate with qualifications and experience. The University of Iowa is an Equal Opportunity and Affirmative Action employer. Women and minorities are strongly encouraged to apply. Submit a letter of interest and CV to Gerald J. Jogerst, MD, Interim Department Head, Department of Family Practice, 2149 Steindler Building, Iowa City, Iowa 52242-1097; 319/335-8454.

Primary Care Physicians and Subspecialists—Are being sought for a variety of group practices located throughout the upper Midwest and New York state. Choose from metropolitan cities, college towns, popular resort communities or traditional rural distinctions. This month, opportunities available for physicians specializing in family practice, internal medicine, pediatrics, occupational medicine, hematology/oncology and nephrology. New opportunities monthly! For all of the facts, call 800/243-4353 or write to Strelcheck and Associates, 10624 North Port Washington Road, Mequon, Wisconsin 53092.

New Openings Daily—FP, IM, OB/GYN, PED. We track every community in the country. Call now for details. The Curare Group, Inc.; 800/880-2028.

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Quality Recruiters

**P.O. Box 1075
Fort Dodge, IA 50501
Phone 1-800-822-8567
Fax 1-515-573-3879**

Here's to your Health

The Iowa Medical Society has published 4 patient inserts in recent months on various topics: low back pain, vaccinations, menopause and estrogen therapy and prostate cancer. Original inserts may be purchased for 15 cents each plus postage. A bill will accompany your insert order.

Call Jane Nieland or Bev Corron at 800/747-3070 or 223-1401 to order inserts or send the completed form below to: *Iowa Medicine*, 1001 Grand Avenue, West Des Moines, IA 50265.

Name _____

Address _____

City _____ State _____ Zip _____

Insert ordered:

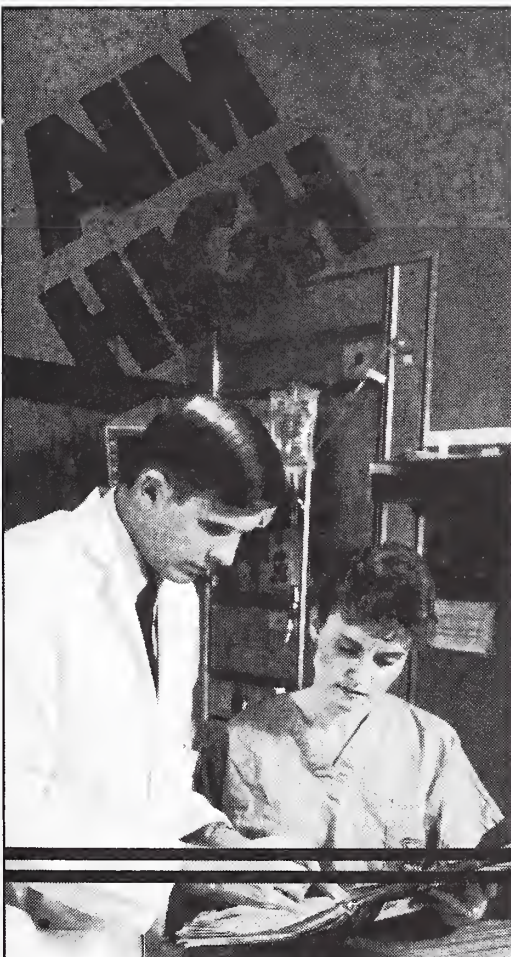
Number of inserts

_____ Low back pain

_____ Menopause/estrogen therapy

_____ Prostate cancer

_____ Vaccinations



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Des Moines 50309
515/243-0590
Allergy & Immunology

Allergy Institute, PC
A.Y. Al-Shash, MD
R.K. Agarwal, MD
1701 22nd Street, Suite 201
West Des Moines 50266
515/223-8622

Pediatric and Adult Allergy, PC
Veljko K. Zivkovich, MD
Robert A. Colman, MD
1212 Pleasant, Suite 110
Des Moines 50309
515/244-7229
Asthma, Allergy & Immunology

Dermatology

Robert J. Barry, MD
1030 Fifth Avenue, SE
Cedar Rapids 52403
319/366-7541
*Practice Limited to Disease,
Cancer and Surgery of Skin*

Fort Dodge Medical Center, PC
Carey A. Bligard, MD, FAAD
James D. Bunker, MD, FAAD
800 Kenyon Road
Fort Dodge 50501
515/574-6850

Electrodiagnosis

John Milner-Brage, MD
208 St. Francis Professional Building
Waterloo 50702
319/234-6446
*Electromyography & Nerve
Conduction Studies*
*Certified by American Board of
Electrodiagnostic Medicine*

Emergency Medicine

Acute Care, Inc.
P.O. Box 515
Ankeny 50021
515/964-2772 or 1-800/729-7813
*Comprehensive Emergency Medicine
Practice, Locum Tenens,
Doctor on Call*

Emergency Practice Associates
P.O. Box 1260
Waterloo 50704
1-800/458-5003
*Specialists in Emergency
Staffing & Emergency Department Services*

Family Practice

Acute Care, Inc.
P.O. Box 515
Ankeny 50021
515/964-2772 or 1-800/729-7813
*Locum Tenens
Doctor on Call*

Infectious Diseases

**Chest, Infectious Diseases & Critical Care
Associates, PC**
Daniel H. Gervieh, MD
Daniel J. Schroeder, MD
Ravi K. Vemuri, MD
Infectious Diseases
1601 NW 114th, Suite 347
Des Moines 50325-7072
24 Hours 515/224-1777

Infertility

Mid-Iowa Fertility, PC
Donald C. Young, DO
3408 Woodland Avenue, Suite 302
West Des Moines 50266
515/222-3060
*Reproductive Endocrinology/Infertility
IVF and GIFT Procedures
Donor Oocyte Program
Artificial Inseminations
Reproductive Surgery
Menopause Management*

Internal Medicine

Fort Dodge Medical Center, PC
Cardiology
Samir G. Artoul, MD, FICC
515/574-6840
Gastroenterology
Kenneth W. Adams, DO, AOBIM
General Internal Medicine
William C. Robb, MD
Richard H. Brandt, MD, ABIM
Grace Z. Ang, MD
800 Kenyon Road
Fort Dodge 50501
515/574-6820

Neurology

Iowa Medical Clinic Neurology
Andrew C. Peterson, MD
Laurence S. Krain, MD
600 7th Street SE
Cedar Rapids 52401
319/398-1721
*Neurology, EEG, EMG, Evoked Potentials
and Sleep Studies*

Fort Dodge Medical Center, PC
Jugal T. Raval, MD, MBBS
800 Kenyon Road
Fort Dodge 50501
515/574-6845

Neurosurgery

**Iowa Medical Clinic
Neurosurgery**
James R. Lamorgese, MD
600 7th Street, SE
Cedar Rapids 52401
319/366-0481
Practice limited to Neurosurgery

Hosung Chung, MD
2710 St. Francis Drive, Suite 401
Waterloo 50702
319/232-8756; fax 319/232-5703
Practice limited to Neurosurgery

Robert Hayne, MD
Thomas A. Carlstrom, MD
David J. Boarini, MD
 1215 Pleasant, Suite 608
 Des Moines 50309
 515/283-5760
Neurological Surgery

Des Moines Neurosurgeons, PC
Robert C. Jones, MD
S. Randy Winston, MD
Douglas R. Koontz, MD
 2600 Grand Avenue, Suite 210
 Des Moines 50312; 515/283-2217

Chad D. Abernathy, MD
 1953 1st Avenue SE
 Cedar Rapids 52402
 319/363-4622
Neurological Surgery

Obstetrics/Gynecology

Fort Dodge Medical Center, PC
Brian L. Welch, MD
 800 Kenyon Road
 Fort Dodge 50501
 515/574-6870

Ophthalmology

Ophthalmic Associates, PC
Robert D. Whinery, MD
Stephen H. Wolken, MD
Robert B. Goffstein, MD
Lyse S. Strnad, MD
 540 E. Jefferson, Suite 201
 Iowa City 52245
 319/338-3623

North Iowa Eye Clinic, PC
Addison W. Brown, Jr., MD
Michael L. Long, MD
Bradley L. Isaak, MD
Randall S. Brenton, MD
James L. Dummert, MD
 3121 4th Street, S.W.
 P.O. Box 1877
 Mason City 50401
 515/423-8861

Timothy F. Moran, Jr., MD
 700 4th Street, Suite 305
 Sioux City 51101
 712/252-4333
General Ophthalmology

Wolfe Clinic, PC
Russell H. Watt, MD
John M. Graether, MD
Gilbert W. Harris, MD
James A. Davison, MD
Norman F. Woodlief, MD
Eric W. Bligard, MD
David D. Saggau, MD
Steven C. Johnson, MD
Todd W. Gothard, MD
 309 East Church
 Marshalltown 50158
 515/754-6200

Satellite Offices
 Lakeview Medical Park
 6000 University Avenue, Suite 300
 West Des Moines 50266
 515/223-8685
 804 South Kenyon Road, Suite 100
 Fort Dodge 50501
 515/576-7777

Sartori Professional Building
 516 South Division Street
 Cedar Falls 50613
 319/277-0103
 214 - 13th Street Southeast
 Cedar Rapids 52403
 319/362-8032

Orthopaedics

Iowa Orthopaedic Center, PC
Marvin H. Dubansky, MD
Marshall Flapan, MD
Sinesio Misol, MD
Joshua D. Kimelman, DO
Timothy G. Kenney, MD
Lynn M. Lindaman, MD
Jeffrey M. Farber, MD
Kyle S. Galles, MD
Scott A. Meyer, MD
Cassim M. Igram, MD
Donna J. Bahls, MD
Jill R. Meilahn, DO
Jacqueline M. Stoken, DO
 411 Laurel, Suite 3300
 Des Moines 50314
 515/247-8400

Orthopaedic Surgery

Fort Dodge Medical Center, PC
C. Mark Race, MD
 800 Kenyon Road
 Fort Dodge 50501
 515/574-6880

Otolaryngology

Iowa ENT, PC
Thomas A. Eriksen, MD
Marshall C. Greiman, MD
Steven R. Herwig, DO
Thomas O. Paulson, MD
Mark K. Zlab, MD
 1-800/248-4443
 1215 Pleasant, Suite 408
 Des Moines 50309
 515/241-5780

1200 35th Street, Suite 200
 West Des Moines 50266
 515/225-7761
 Satellite Clinics:

*Pella, Perry, Newton, Indianola,
 Oskaloosa, Guthrie Center, Lakeview
 Medical Park-West Des Moines*

Wolfe Clinic, PC
Michael W. Hill, MD
Daniel J. Blum, MD
 309 East Church
 Marshalltown 50158
 515/752-1566

Lakeview Medical Park
 6000 University Avenue, Suite 310
 West Des Moines 50266
 515/224-9533

Sartori Professional Building
 516 South Division Street
 Cedar Falls 50613
 319/277-3105

*Otolaryngology-Head and Neck Surgery,
 Facial Plastic Surgery, Allergy*

Phillip A. Linqvist, DO, PC
 1000 Illinois
 Des Moines 50314
 515/244-5225

*Ear, Nose and Throat Surgery,
 Facial Plastic Surgery, Head
 and Neck Surgery*

(Continued next page)

Professional Listing Rates

Physician members of the Iowa Medical Society may advertise in this directory. Monthly rates are as follows: \$10.00 first 3 lines; \$2.00 each additional line. Billed yearly. May be prorated. Send or fax copy to Iowa Medical Society, 1001 Grand Avenue, West Des Moines, Iowa 50265-3599, fax 515/223-8420.

Iowa Head and Neck Associates, PC**Robert T. Brown, MD****Eugene Peterson, MD****Richard B. Merrick, MD**

3901 Ingersoll

Des Moines 50312

515/274-9135

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310 North Grandview Avenue

Dubuque 52001

319/588-0506

Otologic Medical Services, PC**Roger A. Simpson, MD****Guy E. McFarland, MD****Thomas F. Viner, MD****Douglas E. Dawson, MD**

540 E. Jefferson, Suite 401

Iowa City 52245

319/351-5680

1-800/642-6217

*Maxillofacial, Plastic, Head & Neck
Surgery***Robert G. Smits, MD, PC**

1040 5th Avenue

Des Moines 50314

515/244-8152

1-800/622-0002

*Ear, Nose and Throat Surgery,
Facial Plastic Surgery and Head and
Neck Surgery***Pain Management****Iowa Medical Clinic Outpatient Pain****Treatment Center****James R. LaMorgese, MD, FACS,****Neurosurgeon, Medical Director****Sandra Gannon, LSW, ACSW, Program
Director**

600 7th Street SE

Cedar Rapids 52401

319/399-2013

*Neurology, Psychiatry, Anesthesiology,
Rheumatology***Perinatology****Des Moines Perinatal Center, PC****Neil T. Mandsager, MD**

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Rehabilitation****Genesis Regional Rehabilitation Center****Genesis Medical Center**

1227 East Rusholme Street

Davenport 52803

319/383-1466

Maurice D. Schnell, MD**Fareeduddin Ahmed, MD****Arthur B. Searle, MD****Bogdan E. Kryzstofiak, MD****Rehabilitation Medicine Associates****William D. deGravelles, Jr., MD****Charles F. Denhart, MD****Marvin M. Hurd, MD****William C. Koenig, Jr., MD****Karen Kienker, MD****Todd C. Troll, MD****Lori A. Sapp, MD****Younker Rehabilitation Center****Iowa Methodist Medical Center**

1200 Pleasant

Des Moines 50308

515/241-6434

2600 Grand Avenue, Suite 102

Des Moines 50312

515/283-1570

Pulmonary Medicine**Fort Dodge Medical Center, PC****Robert C. Ang, MD, FCCP**

800 Kenyon Road

Fort Dodge 50501

515/574-6820

**Chest, Infectious Diseases & Critical Care
Associates, PC****Roger T. Liu, MD****Steven G. Berry, MD****Donald L. Burrows, MD****Michael Witte, DO****Gerard A. Matysik, DO**

1601 NW 114th, Suite 347

Des Moines 50325-7072

24 Hour 515/224-1777

*Pulmonary Diseases***Surgery****Wendell Downing, MD**

1212 Pleasant Street, Suite 410

Des Moines 50309

515/241-5767

*Diseases and Surgery of the Colon and
Rectum***Fort Dodge Medical Center, PC****Ralph E. Woodard, MD, FACS****Dan P. Warlick, MD, FACS**

800 Kenyon Road

Fort Dodge 50501

515/574-6865

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Physician survey on domestic violence

IOWA MEDICAL SOCIETY

This survey of Iowa physicians is part of a comprehensive project of the Iowa Medical Society's Task Force on Domestic Violence. The questions in this survey focus on domestic violence, which is defined as abuse between intimate partners. The task force will use the results of the survey to determine future educational efforts for physicians. Many of these questions have no right or wrong answers. Please fold your completed survey in half so the Iowa Medical Society's return address is on the outside, staple or tape it shut, affix a stamp and drop it in a mailbox. The deadline to return your survey is January 25. Thank you for your assistance.

Rebecca Wiese, MD

Chair, IMS Task Force on Domestic Violence

Name (optional) _____

1. What is your specialty? _____

2. What best describes your practice setting?

_____ Medical practice/group _____ Academic

_____ Hospital _____ Administration

3. Your age _____ Gender: Male _____ Female _____

4. Describe the frequency with which you treat victims of domestic violence.

_____ Frequently

_____ Occasionally

_____ Seldom

5. How capable do you feel of recognizing victims of domestic violence?

_____ Very capable

_____ Somewhat capable

_____ Not capable

6. How capable do you feel of intervening with victims of domestic violence?

_____ Very capable

_____ Somewhat capable

_____ Not capable

7. How comfortable do you feel asking patients if they have been abused?

_____ Very comfortable

_____ Somewhat comfortable

_____ Not comfortable

8. Have members of your office staff received education regarding domestic violence?

_____ Yes

_____ No

9. How successful are you in getting patients to discuss domestic violence?

_____ Successful

_____ Somewhat successful

_____ Not successful

10. Do you have the information you need to recognize and intervene in cases of domestic violence?

_____ Have enough information

_____ Could use more information

_____ Have no information

11. Would you distribute information to patients you suspect are suffering from domestic violence?

_____ Yes

_____ No

12. You would be interested in receiving information on which of the following aspects of abuse:

_____ Physical indicators in patients

_____ Behavioral indicators in patients

_____ Characteristics of abusers

_____ Legal obligations, ramifications

_____ Liability issues

_____ Intervention strategies

_____ Referral options

_____ Ethical issues

_____ Other (please specify) _____

13. Are you aware of domestic violence resources and services in your community?

_____ Yes

_____ No

14. If yes, do you refer patients to existing domestic violence agencies or services?

_____ Yes

_____ No

15. If no, would you like information on existing services and referral resources?

☐ Yes

☐ No

16. If you intervene with a victim of domestic violence and she returns home to her abuser, you have failed.

☐ True

☐ False

17. It is alright to call the police or social service agencies without the victim's consent.

☐ True

☐ False

18. Victims of domestic abuse should always be interviewed alone.

☐ True

☐ False

19. Pregnant women are rarely battered.

☐ True

☐ False

20. Eventually, most women leave violent relationships.

☐ True

☐ False

21. If physicians treat the problem of alcohol or substance use and abuse, they will also be treating and possibly preventing domestic violence.

☐ True

☐ False

22. Victims of domestic abuse rarely seek treatment for the signs and symptoms of abuse.

☐ True

☐ False

23. Couples' counseling or family intervention is contraindicated for domestic violence situations.

☐ True

☐ False

24. All women who are depressed or who have attempted suicide should be screened for domestic abuse.

☐ True

☐ False

25. Women who abuse drugs or alcohol are more likely to be victims of domestic violence.

☐ True

☐ False

26. Physicians should not document abuse in the patient's chart unless the patient confirms abuse has occurred.

☐ True

☐ False

27. If a woman misses or cancels an appointment, she should be screened for domestic abuse.

☐ True

☐ False

28. When screening for domestic abuse, it is better to ask specific rather than open-ended questions.

☐ True

☐ False

29. Nonspecific physical complaints such as GI upset, insomnia, nightmares or anxiety can be indicators of domestic abuse.

☐ True

☐ False

30. More often than not, domestic abuse victims will deny they are being abused.

☐ True

☐ False

31. Which of the following are clinical signs of possible domestic abuse? (Check as many as apply)

☐ Recurrent STDs

☐ Migraines

☐ Anxiety during pregnancy

☐ Casual response to serious injury

☐ Anorexia or bulimia

☐ Facial lacerations

☐ Non-specific pain

☐ Palpitations or dizziness

Domestic abuse scenarios

Please read the following scenarios and then choose the course(s) of action you would take.

Scenario 1 (Submitted by J.W. Ankeny, DO, Des Moines)

A single, 25 year-old nurse at a metropolitan hospital presents to her family physician's office on multiple occasions for vaginal discharge. Repeated physical examinations and laboratory workups provide no diagnosis. Non-specific treatments for vaginal infections provide no relief to the patient. The patient presents yet again for the same complaint. The physician should:

- ☐ (1) Reevaluate the patient physically and through laboratory tests.
- ☐ (2) Refer her to an OB/Gyn specialist
- ☐ (3) Question the patient about her social history including sexual preference, dating history, family and living situation, method of contraception, etc.
- ☐ (4) Review the screening protocols for domestic abuse with the patient.

According to Dr. Ankeny, this real life patient was questioned (3) about her living situation and was found to be cohabitating with a policeman. He was physically abusing her with the tools of his trade. Upon this revelation, the patient was referred for counseling and a positive outcome ensued.

Scenario 2 (Submitted by Robert McAfee, MD, president of the American Medical Association)

An older, middle-aged woman, the wife of a respected businessman in a small city, presents in the office of a surgeon complaining of breast pain. She has a family history of breast cancer. The physician examines her and orders a mammography, the results of which are normal. The physician relates the mammography results to the patient, reassuring her that everything is fine. He asks her to visit him again in six months. However, less than three months later she returns, again complaining of breast pain. The physician should:

- ☐ (1) Conduct another physical examination.
- ☐ (2) Do another mammography.
- ☐ (3) Refer her to a specialist.
- ☐ (4) Consider the screening protocols for domestic abuse.
- ☐ (5) Search the literature for articles on breast pain.

According to Dr. McAfee, during the woman's third visit, he reexamined her (1) and noticed bruises on her chest. She was actually a victim of long-term abuse by her husband. He intervened and referred the woman's husband to appropriate counseling which proved successful.

FOLD IN HALF

Place
Stamp
Here

Iowa Medical Society
1001 Grand Avenue
West Des Moines, IA 50265

The AMA in action

Sitting in on the AMA interim meeting is an emotional roller coaster. Sometimes you can actually feel the train building up steam, rolling over the opposition toward the final vote. At times, it appears arguments are rehearsed with speakers rising from different areas of the hall to make their case. Such arguments have a good chance of being accepted. Knowledge of the issues, timeliness and personal association all make an impact. Resolutions upon which the delegates agree become the policy your AMA staff pursues.

The AMA is involved in a wide range of issues which affect the way we practice medicine, our medical school and post graduate education, the regulations under which we work and the way we are paid. The governmental bureaucracy gets information and recommendations from many constituents. These recommendations are not beneficial for physicians or their patients. This impresses upon us the need for a united physician organization working for positive influences on our patient's health.

My assignment was reference committee "E" chaired by a fellow North Central Medical Conference member, Richard Tompkins, a rheumatologist from Mayo Clinic. A resolution that may affect your journal reading dealt with sexually exploitative advertising to physicians. The women's section and student section didn't think it proper that medical products and technology ads should feature exposed female parts in various poses. The

House of Delegates approved their resolution.

Another resolution concerning female genital mutilation sparked a lengthy discussion. Its history, cultural background and countries where practiced entered the informative discussion. In the end, a resolution was approved calling for counseling against the practice.

Managed care took center stage at this meeting. The Board of Trustees presented a 57-page report describing current trends, risks and opportunities for patients and physicians. A detailed AMA strategy for managed care and the private sector was presented. You can get a copy of "Managed Care and the Market", a summary of national trends affecting physicians, from your state or national organization. The House of Delegates approved the report

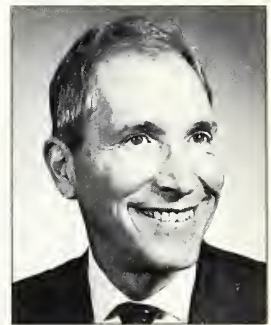
Managed care took center stage at the AMA interim meeting.

and emphasized four principles:

1. Professionalism (medical science and ethics)
2. Patient and physician autonomy
3. Patient and physician rights
4. Practical assistance to physicians

Health system reform, employer control of health insurance choices, AMA budget, antibiotic usage and bacterial resistance and control of *E. coli* infection were other issues your House of Delegates acted upon.

I came away with the realization that the AMA and many of your fellow physicians are working to keep American medicine the best in the world for all of us. **IM**



JAMES WHITE, MD

**YOU
JUST CAN'T
BEAT THE
BLUES**



**BlueCross BlueShield
of Iowa**

**Provider Service Center:
Statewide: 800-362-2218
Des Moines: 515-245-4688**

North Iowa responds to domestic violence

Improving the health status of Iowans through an integrated system of hospitals, physicians and other quality health care services is the vision of North Iowa Mercy Health Center located in Mason City, Iowa.

In response to this charge, the NIMHC Women's Health Center is developing a community approach to domestic violence as part of the Center's quality improvement process.

Working with the Crisis Intervention Center and members of the North Iowa Batters Education Task Force, professional education regarding identification and intervention with survivors of domestic abuse was selected as our community's greatest need in the area of domestic violence.

The hospital's Regional Health Education Center has assisted us in providing a continuing education program targeting nurses, social workers and physicians and has purchased a professional educational video series entitled "More Than Just Words: Responding to Domestic Violence". This program, in conjunction with educational materials developed by the Iowa Medical Society, will be utilized to increase skills of all health professionals within the north Iowa network of Mercy hospitals and physician clinics.

Since studies show that 25% to 35% of women who visit emergency departments are there for symptoms related to ongoing domestic abuse, NIMHC Emergency Center personnel are participating in the initial inservice training.

In addition, the Women's Center is part of a hospital task force to enhance existing procedures and to develop screening criteria which will be applicable to all health care providers (including physician clinics) in the North Iowa Mercy System.

The Cerro Gordo County Medical Alliance has offered to assist in the support and dissemination of information throughout northern Iowa. Posters with resource information developed in cooperation with the IMS will be placed in public places such as women's restrooms where they will be readily and safely available.

Goals for the future include the development of an ongoing multidisciplinary task force to identify, develop and monitor services to survivors of domestic violence, enhance health care

providers' use of advocates and assist in supporting existing services.

A task force of the Iowa Supreme Court, the AMA, JCAHO and other experts in the field of domestic violence agree that physicians and community hospitals serve a key role in addressing and

preventing domestic violence. Together we have an opportunity and obligation to improve the quality of life for these survivors and their families. We at North Iowa Mercy Health Center have gladly accepted the challenge to provide leadership in addressing domestic violence to improve the health of the community in which we live. ■

The Women's Health Center is developing a community approach to domestic violence.



MAXINE BRINKMAN

Ms. Brinkman is director of the Women's Health Center in Mason City, Iowa and an IMS Alliance member. The Women's Health Center, a service of North Iowa Mercy Health Center, provides a multidisciplinary approach to primary health care.

IMS Update

AT A GLANCE

According to a recent issue of JAMA, nearly 44% of college students are binge drinkers and nearly 20% binge drink on a regular basis. Colleges in the Northeast and North Central regions of the U.S. had higher rates of binge drinking than those in the West or South.

As of press time, President Clinton was continuing the search for a replacement for U.S. Surgeon General Joycelyn Elders, who was fired for comments made during an appearance at the United Nations. While the president denied Dr. Elders was fired for political reasons, AM News speculated the president is "actively positioning himself as a moderate Democrat and can no longer afford to be undermined by his own surgeon general".

IMS represented at AMA interim meeting

Iowa delegates were among 413 physicians participating in the December AMA Interim Meeting, a meeting dominated by discussion of managed care issues.

The AMA Board of Trustees presented a 57-page report describing current trends in managed care, summarizing risks and opportunities for physicians and patients and presenting detailed AMA strategy for managed care and the private sector.

The report emphasizes four principles — professionalism, patient and physician autonomy, patient and physician rights and practical assistance to physicians.

The House adopted a substitute resolution calling on the AMA to undertake or continue these activities:

- Support at the federal and state level for the Patient Protection Act.
- Publicize cost factors which contribute to escalation of health care costs, including patient responsibility and administration.
- Support state and county efforts on behalf of member physicians deselected by managed care plans for other than quality reasons.
- Investigate and publicize the ways managed care can be involved in education, training and research.
- Evaluate the impact of managed care plans on medical care quality and medical ethics and identify practices that adversely affect delivery of quality health care.

The AMA House also reordered the AMA's health system reform priorities, placing more emphasis on regulation of managed care plans and less on universal coverage. According to *AM News*, the move "reflects political realities under the new Republican-controlled Congress"

The AMA's top reform priorities are: legislative protection of physician and patient autonomy under managed care, curbs on malpractice suits, insurance reform limiting

carriers' risk-selection practices, antitrust relief, more freedom for physicians to take collective action and creation of tax-sheltered medical savings accounts.

The AMA is also prepared to do battle with Republicans on further reductions in Medicare and Medicaid reimbursement to providers.

In other matters, a resolution introduced by the Iowa delegation through the North Central Medical Conference calling for a study of reimbursement for telemedicine procedures was approved by the AMA House.

Also, considerable concern was expressed at a reference committee hearing regarding presentation of smokers' rights articles in *Weekly Reader* without accompanying information on the adverse effects of tobacco use.

Final dues notice will be sent this month

The fourth and final IMS/AMA dues notice will be sent to IMS members in mid-February. Dues are considered delinquent on March 1. Prompt payment of dues will be appreciated.

SPECIALTY SOCIETY UPDATE

The second Management Education Program (MEP) begins March 24. This physician and manager leadership program is designed for graduate level students. Call Dana Petrowsky, 800/728-5398, for more information.

The Iowa Psychiatric Society Spring Meeting will be April 7 at the Des Moines Marriott.

Dr. Roy Overton, president of the American Medical Directors Association, Iowa Chapter, will represent Iowa at the White House Conference on Aging this spring in Washington, DC.

There will be an Iowa Chapter Night reception at the American College of Cardiology annual meeting at the New Orleans Hilton March 20.

The Iowa Association of County Medical Examiners will meet Friday, February 17 at 2 p.m. at IMS headquarters.

Domestic abuse topic at Scientific Session

A panel discussion of domestic abuse will culminate the 1995 IMS Scientific Session April 28-30 at the Marriott Hotel in Des Moines. The Scientific Session will be held in conjunction with the 1995 House of Delegates meeting.

Participating in the panel discussion will be an attorney, a police officer, an emergency room physician, advocates for battered women and Dr. Lonnie Bristow, president-elect of the American Medical Association.

The 1995 Scientific Session will begin Friday, April 28. Topics include diabetic retinopathy, asthma deaths, the tube and tonsil controversy and a special presentation on Iowa's trauma plan and the United Airlines crash in Sioux City.

Watch the March *Iowa Medicine* for a detailed Scientific Session program and registration information. You are encouraged to reserve your hotel room in advance by calling the Marriott at 800/228-9290.

Award nominees sought

IMS is seeking nominees for its Physician Award for Community Service and for the Outstanding Iowa Medical Office Administrator Award. These awards will be presented during the 1995 House of Delegates.

Anyone can nominate a physician for the Community Service award by writing to Tina Preftakes at the IMS, 1001 Grand, West Des Moines, IA 50265. The deadline is March 1.

To nominate someone for the clinic manager award, call Dana Petrowsky at IMS Services, 515/223-2816 or 800/728-5398 by February 15.

IMS election process continues

Delegates to the 1995 IMS Nominating Committee are being chosen at district caucuses around Iowa. The Nominating Committee will meet March 12 by telephone to assemble the candidate slate for the 1995 elections. The election will take place Sunday, April 30 during the IMS House of Delegates meeting.

Offices to be filled include: president-elect, vice president, trustee, House of Delegates speaker and vice-speaker, one AMA delegate and one AMA alternate.

FOCUS ON IMS ALLIANCE


The IMS Alliance is committed to the concept of "Zero Tolerance for Violence". Initiatives across the state include:

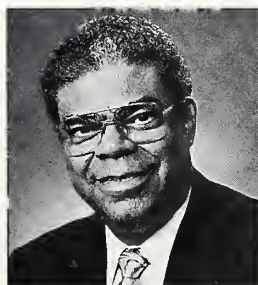
- Karen Johns, Cedar Rapids, coordinates distribution of "Careline" crisis cards to all junior high and high schools in Iowa.
- Cindy Ehrecke, Davenport, distributes "I Can Choose" coloring books to grade school students.
- Karen Messamer, Oskaloosa, promotes "Baby Think it Over" dolls for teen pregnancy prevention.
- Adrianne Lugo and Teri Garrett, Iowa City, organized fund-raiser for local domestic violence center.
- Marcia Heggan, Marshalltown, supporter of Domestic Violence Alternatives and Sexual Assault Center.
- Bonnie Zittergruen, Des Moines, member of Iowa Coalition on School Health.
- Carrie Hall, Des Moines; Laurie Stevens, Ankeny; Mary Conway, Emmetsburg — members of the IMSA Spouses Offering Support Committee.
- Marta Abele, Dubuque, active supporter of Battered Women's Program.

Contributed by Barbara Bell, president, IMSA.

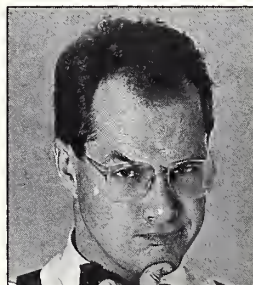
Special guests at IMS Annual Meeting

Dr. Lonnie Bristow, an internist from San Pablo, California, will be a special guest at the IMS House of Delegates April 28-30 at the Marriott Hotel in Des Moines. Dr. Bristow will address the IMS House of Delegates on Saturday, April 29 and will take part in a Sunday morning panel discussion on domestic violence. Dr. Bristow has been a member of the AMA Board of Trustees since 1985.

Dave Werner, a political satirist and former member of the Capitol Steps will entertain at the IMS Annual Banquet Saturday evening. A graduate of Yale Law School and former member of a Washington, DC law firm, Werner has been featured on the CBS Evening News and the Today Show. He is a native of Manchester, Iowa. 



Dr. Bristow



Dave Werner

Futures

AT A GLANCE

Watch the March Iowa Medicine for a reprint of Dr. Robert McAfee's presidential report to the AMA House of Delegates at the December interim meeting. The entertaining presentation is entitled "King Will and the Foul Humours: A Fable for Reform".

In January, the IMS Board of Trustees met with officials of Blue Cross/Blue Shield to discuss the future of private health reform in Iowa. Blue Cross and Blue Shield remains the largest third party carrier in the state.

Futures issues in March *Iowa Medicine*

Iowa physicians are faced with a myriad of options for changing their practice situations, and many are wondering what direction to take.

In the March *Iowa Medicine*, a feature article by an expert discusses pitfalls physicians could encounter when altering their practice situation — whether it be a merger, sale or other move toward managed care.

In the May magazine, a senior financial consultant with a Washington, DC firm will discuss financing of physician-driven managed care ventures.

Medicare Conversion Factors good news

The 1995 Medicare conversion factors (CF) have resulted in the biggest Medicare reimbursement increase for physicians in years. The CFs published in the December 8, 1994 *Federal Register* are \$36.38 (a 7.9% increase) for primary care services, \$39.45 (a 12.2% increase) for surgical care procedures and \$34.62 (a 5.2% increase) for other non-surgical services and procedures.

The CF is used by HCFA to determine the new Medicare fee schedule for services on and after January 1, 1995. Payment is calculated by multiplying the relative value of a service or procedure by the CF and adjusting for local practice costs. (See next article.)

The CFs are based on a formula that includes physician performance in the nation compared to set targets (the Medicare Volume Performance Standards). If the volume of physician services is above the target, the reimbursement rate is lowered. If the volume is below the target, the rate is increased. The 1995 increase is a reward for physician performance in 1993.

Although the big increase has been criticized by economists and others, experts point out that this increase will help close the gap between Medicare payments and private

sector payments. Medicare payments currently are only 59% of private payments. Physician payment accounts for about 23% of total Medicare spending.

The 1995 reimbursement increases are substantially above the inflation rate (2.6%) and consumer price index for medical care cost increases (4.7%). Physicians should not expect similar reimbursement increases every year. HCFA has tightened the Medicare Volume Performance Standards for 1995 — a 13.8% increase in the volume of primary care services, 9.2% for surgical care and 4.4% for nonsurgical care. The reimbursement rate for 1997 will be based on physician performance compared to these targets.

Iowa GPCIs decrease

The Geographic Practice Cost Indices (GPCIs) for Iowa have decreased. The decrease will be phased in over the next two years.

The GPCIs are used by HCFA to adjust for local practice costs when calculating the Medicare fee schedule. OBRA '89 requires that the GPCIs be reviewed and revised if necessary at least every three years. The new GPCIs are based on data from 1990-92.

The GPCI calculation has been widely criticized; however, HCFA stated that the data used are the best sources available. HCFA has announced a study to establish an alternate method for establishing practice expenses, one component of the GPCI. A new methodology would not be implemented until January 1, 1998.

Iowa's GPCIs in 1995 will be .968 (work), .898 (practice expense) and .672 (malpractice). In 1996, they will be .960 (work), .877 (practice expense) and .679 (malpractice).

This is a decrease of -1.9% in Iowa. Changes throughout the country ranged from a nearly 8% increase in Rhode Island to a -6 to -8% decrease in Illinois.

For more information on the Iowa GPCIs, call Barb Heck at the IMS, 800/747-3070.

HMOs 'awash in cash'

According to a recent article in the *Wall Street Journal*, HMOs are "so awash in cash they don't know what to do with it all". During the past year, liquid assets of many HMOs have climbed 15% or more.

Four of the industry's biggest companies have tucked away more than \$1 billion and some midsize HMOs are sitting on \$500 million each. Thanks to rapid membership growth and slowing medical costs, many HMOs are pulling in money faster than they can spend it.

Dr. James Todd of the AMA was quoted recently as saying the AMA "has some real problems with the for-profit mentality of some health plans."

AMA: FINANCING REFORM ESSENTIAL TO PRESERVE MEDICARE PROGRAM

Below are excerpts of a response by AMA President Dr. Robert McAfee to the entitlement commission report issued by Senators Kerrey and Danforth:

"Despite concerns with some policy options, the AMA believes the Bipartisan Commission on Entitlements and Tax Reform report creates the context for a much needed national debate on the future financial health of the Medicare program. Medicare is at a crossroads. Without comprehensive restructuring, Medicare is headed for a fiscal train wreck early in the next century.

"The AMA has significant concerns about proposals to cut reimbursement. This short-sighted approach avoids the underlying problems, exacerbates private sector cost shifting and limits access to care for the neediest Medicare patients.

"Increases in medical costs have moderated. Recently, the government reported that private sector health care spending increased at its lowest rate in a decade with physician services making the smallest increase — 5.9% — of any sector. According to the Physician Payment Review Commission, physician payments under Medicare in 1993 increased at one-half of the consumer price index inflation rate and substantially below all other Medicare categories.

"A careful examination of the facts must precede hasty imposition of politically expedient, short-term budget cuts that cover up the problem and endanger the future care of the elderly and disabled. Arbitrary spending slashes and provider payment rate cuts are not solutions and will be vigorously opposed by the AMA."

IMS HAS CASSETTES ON MANAGED CARE ISSUES

If you missed the Iowa Medical Society's "Organizing for Change" conference, you can order a set of cassette tapes containing the entire program, including an entertaining presentation on the Washington scene from Dr. James Todd of the AMA. Here's what Iowa physicians said about the conference speakers:

"A high quality program — keep them coming."

"Plenty of useful, practical advice."

"I wish all Iowa physicians could hear this program."

The set of cassette tapes and related materials is \$42; the cassette tapes alone are \$26.25. To order, call Linda Tideback at the IMS, 800/747-3070.

Getting them to want you

In the January, 1995 *California Physician*, an attorney offered the following ten tips on how to get a managed care plan to want you:

1. Promote your practice not only to health plans, but also to potential patients and colleagues.

2. Retain existing patients because a large patient base improves your chances of being accepted by a plan.

3. If you are a specialist, get to know the plan's primary care physicians and what they expect from specialists.

4. Ask your patients to advocate for your participation.


5. Mingle with business groups.

6. "Court" the plan by taking someone from the plan out to lunch. Learn as much as you can about the plan from the administrator or medical director.

7. Computerize so you can generate encounter and outcomes data quickly.

8. Compare yourselves using UR data (no names) to learn how to perform better.

9. Run your office efficiently by cross-training employees.

10. Make sure your credentials are up to par. 

Legislative Affairs

AT A GLANCE

The IMS has position papers outlining IMS policy on a number of key issues including any willing provider, managed care, liability reform and tobacco issues. For copies, call Lyn Durante at the IMS, 515/223-1401 or toll-free 800/747-3070.

According to a recent Des Moines Register article, the legislature and governor are "tired of waiting for the federal government to do something about health care problems" so are moving ahead with their own agenda. The agenda will include a proposal to limit non-economic damages and the statute of limitations in medical malpractice cases. Insurance reform proposals including elimination of pre-existing conditions are also anticipated.

IMS cosponsors telemedicine conference

The Iowa Medical Society was a cosponsor of the largest videoconference ever held on Iowa's fiber optics network Monday evening, January 9. There were nearly 1,000 conference registrants at 59 sites around Iowa.

Three expert panels discussed key issues raised by telemedicine technology, including reimbursement, liability, confidentiality and physician licensure.

Several IMS member physicians participated on the panels. There was also a demonstration of a cardiology consult between a Des Moines physician and a physician in Jefferson. Though Iowa has become a worldwide leader in this technology, everyone agreed that, at this point, no one has answers for the many questions raised by telemedicine technology. Among key issues discussed during the conference were:

- How will rural hospitals be able to afford the equipment to use telemedicine? (There was general consensus that unless rural hospitals receive financial assistance, telemedicine technology will not be feasible for them.)

- When will HCFA decide to reimburse for telemedicine services to Medicare patients? (A HCFA representative said that agency needs "more clinical data" which proves telemedicine is safe and effective.)

- How will the move toward capitation affect reimbursement for telemedicine?

- Will third party payers be willing to pay for the increased access to specialists made possible by telemedicine?

- Who is liable if the quality of a transmission is poor?

- Will physicians consulting from out-of-state offices need Iowa licenses? Who is being electronically transported?

- How will patient confidentiality be protected?

IMS has available a videotape of the conference and a report from the Iowa Telemedicine Advisory Council. Call Becky Roorda at the IMS, 800/747-3070.

CONTACTING YOUR LEGISLATORS

Telephone number during the session:

Senators 515/281-3371
Representatives 515/281-3221
Governor 515/281-5211

Write to them at:
STATEHOUSE
Des Moines, Iowa 50319

You may also contact your legislators at home when the legislature is not in session. If you don't know who your legislator is or need your legislator's home address and phone number, call Lyn Durante of the IMS staff, 800/747-3070 or 515/223-1401.

Iowa Senate, House committee chairs

Following are chairs of committees which deal with health care issues in the Iowa Legislature:

SENATE

Human Resources
Judiciary
State Government
Commerce
Communications
Appropriations

BUDGET SUBCOMMITTEES
Human Resources
Human Services

Sen. Elaine Szymoniak
Sen. Randal Gianetto
Sen. Michael Gronstal
Sen. Patrick Deluhery
Sen. Robert Dvorsky
Sen. Larry Murphy

Sen. Tom Flynn
Sen. Johnie Hammond

HOUSE

Appropriations
Commerce/Regulations
Human Resources
Judiciary
State Government
Technology

BUDGET SUBCOMMITTEES
Health Human Rights
Human Services

Rep. David Millage
Rep. Janet Metcalf
Rep. Horace Daggett
Rep. Charles Hurley
Rep. Mona Martin
Rep. Bob Brunkhorst

Rep. Joseph Kremer
Rep. Hubert Houser

IMS "Medicine Day" at Iowa legislature

Wednesday, March 22 will be 'Medicine Day' at the Iowa Legislature — a day for Iowa physicians, physician spouses and clinic

managers to see first-hand how the legislative process works.

Medicine Day is open to any IMS member. The day will include luncheon at IMS headquarters and an afternoon at the statehouse talking to legislators, attending committee meetings and listening to debate.

To register or for more information, call Paul Bishop or Lyn Durante at the IMS, 515/223-1401 or 800/747-3070. Registration deadline is March 10.

Free substance abuse directory available

The IMS Committee on Maternal and Child Health and the Maternal Mortality Committee urge all physicians to screen patients — especially pregnant women — for possible substance abuse. Treatment may include referral to a state-funded agency.

To get a free directory of all state substance abuse programs, contact the Iowa Substance Abuse Information Center, 800/247-0614.

The Center is required to provide services to pregnant women with alcohol or other substance abuse problems. Services are offered free or on a sliding fee scale.

Any willing provider

The "any willing provider" issue is expected to be discussed during the 1995 legislative session. The IMS is part of a coalition opposing legislation requiring managed care plans to include any provider who agrees to the terms and conditions of the plan.

In 1994, legislation was passed by the Senate to require such plans to provide direct access to services of a long list of providers. The bill died in the House. The IMS opposes this mandate because:

1) It will prevent effective management of care; 2) It will significantly increase the cost of health care coverage; 3) Increased costs may result in fewer employers providing health benefits; 4) State legislation affects only about 25% of the insurance market; 4) Employers may decide to self-insure since federal ERISA regulations do not contain such mandates.

IMS members are encouraged to ask legislators to oppose such mandates. The IMS is negotiating directly with third party payers to ensure physicians and patients are treated fairly by managed care plans. **IM**

Iowa Congressional Delegation and District Offices

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202/225-3806

Davenport headquarters:
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District 2

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Dubuque headquarters:
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District 3

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Iowa WATS: 800/432-1984

District 4

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Des Moines headquarters:
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District 5

Tom Latham
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Sioux City: 712/277-2114
Spencer: 712/262-6480
Orange City: 712/737-8708
Fort Dodge: 515/573-2738

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Charles Grassley (R)

135 Hart Senate Office Bldg.
Washington, DC 20510
202/224-3744

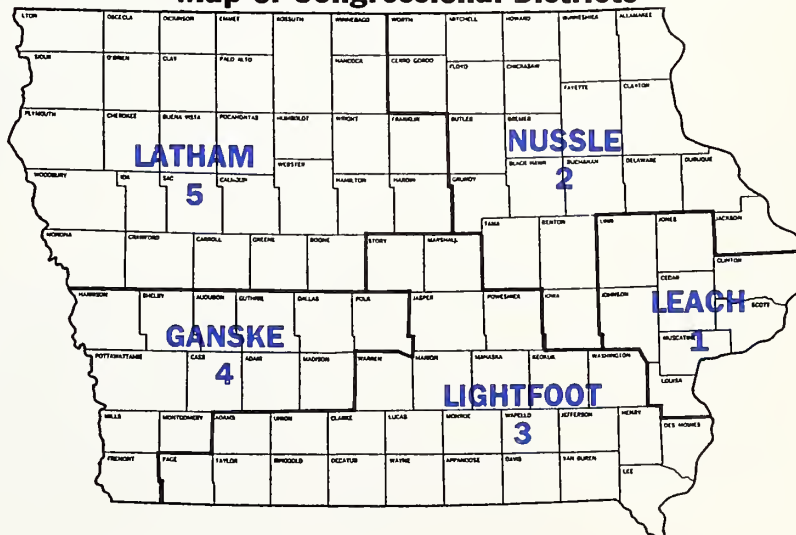
Des Moines: 515/284-4890
Sioux City: 712/233-1860
Waterloo: 319/232-6657
Cedar Rapids: 319/363-6832
Davenport: 319/322-4331

Tom Harkin (D)

531 Hart Senate Office Bldg.
Washington, DC 20510
202/224-3254

Des Moines: 515/284-4574
Cedar Rapids: 319/393-6374
Davenport: 319/322-1338
Council Bluffs: 712/325-0036
Sioux City: 712/252-1550
Dubuque: 319/582-2130

Map of Congressional Districts



Medical Economics

AT A GLANCE

The California Medical Association Board of Trustees authorized CMA to file a lawsuit in US District Court to stop implementation of Prop. 187's health care provisions. The lawsuit says Prop. 187 is unconstitutional and threatens all residents of California with "epidemics of enormous proportions". Prop. 187, says CMA, would breach physicians' professional ethics and place physicians who accept public funds in legal jeopardy.

President Clinton has vetoed federal funding for research on embryos created solely for research purposes, but did not rule out use of federal funds for research on leftover embryos created as part of fertilization treatments at in vitro fertilization clinics.

More legal action in mental health contract

It looks as though implementation of a managed care plan for mental health services to Iowa Medicaid patients has hit another major legal snag.

Value Behavioral Health (VBH) has taken another legal step to defend its original win of the Iowa State Medicaid mental health contract.

In June, 1994, the state announced it had chosen VBH from among eight bidders for the mental health managed care contract. However, Medco, a California firm which was runner-up in the bidding, filed a lawsuit alleging a flawed selection process.

A Polk County judge later ruled in favor of Medco, citing "overwhelming circumstantial evidence of impropriety". He ordered VBH disqualified from the bidding.

Late last year, the \$100 million contract was awarded to Medco.

But the saga doesn't end there. In a recent press release, VBH announced they intended to ask the Iowa District Court for a judicial review and a stay of the contract award by the Iowa Department of Human Services.

The DHS, said the press release, denied VBH's protest of the Medco award. The 11-page protest was filed with the DHS in early December. Value objected to the DHS withdrawal of its original contract award and the awarding of the contract to Medco.

According to the VBH press release, three other unsuccessful vendors also plan to file a motion for a judicial review.

Sound off on RBRVS

The Health Care Financing Administration (HCFA) wants help reviewing its resource-based relative value scale.

The deadline is 60 days after HCFA publishes the request in the *Federal Register*, which was published December 8.

In the first such review, HCFA will consid-

er comments on the relative value units associated with all physician services and procedures. RVUs measure the amount of physician work entailed and are used to calculate payment.

Be sure to reference the appropriate Current Procedural Terminology code and the current RVU for the service in question. If you fail to do this, your comments may not be considered.

Send one original and three copies to: HCFA, Health and Human Services Dept., Attention: BPD-789-FC (5-year refinement), PO Box 26688, Baltimore, MD, 21207.

HCFA will consider all comments as it develops proposed changes, which will be published in the *Federal Register* in 1996. Changes will go into effect January 1, 1997.

For more information on how to sound off on the RBRVS, contact Barb Heek of the IMS staff, 800/747-3070 or 515/223-1401.

Medicaid MediPASS program update

The Iowa Department of Human Services operates two managed health care options: MediPASS and HMOs. There are two HMOs enrolled in the Medicaid Managed Health Care Program — Heritage and Care Choices.

Current MediPASS counties which are adding Care Choices HMO are O'Brien, Buena Vista, Palo Alto, Pocahontas and Sac.

MediPASS and Care Choices will be implemented at the same time in Sioux County.

Current MediPASS counties which are adding Heritage are Dallas, Jasper, Madison, Marion and Warren.

CHMIS update

The Community Health Management Information System Governing Board and its five offshoot committees are continuing to meet to hammer out details of CHMIS implementation in Iowa.

CHMIS will be implemented in three phas-

es in Iowa. As of July 1, 1996, all health care providers must submit claims electronically using a universal claim format. Other phases of CHMIS implementation will require further action by the Iowa Legislature and involve reporting of various data to a central repository and use of electronic patient records.

Many details regarding how the CIIMIS will work have yet to be determined by the Governing Board and five subcommittees.

One subcommittee — the Technical Advisory Committee — met in December and decided to divide into two groups which will study 1) certification standards for networks and 2) base specifications for the CHMIS data repository.


The CHMIS Ethics and Confidentiality Committee also met recently and will break into four groups to study various issues including consumer knowledge of data collected from patient records, legal issues and who should be granted access to the CIIMIS data bank.

The Quality Review Committee is discussing elements of the UB 92 claim form to determine the uniformity among payers.

Meanwhile, the Iowa Medical Society has its own CIIMIS committee which is directing efforts to educate Iowa physicians. IMS staff have scheduled a number of educational meetings around the state during the next few months.

The following CIIMIS educational meetings have been scheduled:

February 13	Skiff Medical Center	Newton
February 17	Ia Assc of County Medical Examiners	IMS
February 20	Cass County Hospital	Atlantic
March 7	Scott County Med Soc	Davenport
April 7	Iowa Psychiatric Soc	DM Marriott
April 22	Iowa Clinical Society of Internal Medicine	Univ of Iowa
May 6	Iowa Urological Soc	University Park Holiday Inn, DM

For information on scheduling a CHMIS presentation by IMS staff, call Donna Bottorff at IMS, 800/747-3070 or 515/223-1401. 

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Practice Management

AT A GLANCE

Enrollment continues in the IMS Services Medical Business Specialist (MBS) program. Anyone enrolling during the first quarter of this year can receive credit for classes taken during 1994. MBS is a certification program for medical office staff, covering 10 broad areas of medical office operations. The program began in March of 1994. For information on how to enroll, call Mary Reinsmoen at IMS Services, 800/728-5398 or 515/223-2816.

Does your office know about CHMIS requirements which will go into effect July 1, 1996? Check out this month's Medical Economics section for more information.

Thirty graduate from MEP

Certificates were presented to the graduates of the first Management Education Program (MEP) at a closing ceremony Saturday, December 17 at IMS headquarters in Des Moines.

Thirty participants completed a 12-month, 120-hour "mini MBA" program that prepares them to understand and handle the business side of medical practice and to be leaders in the changing field of medicine.

Participants in the MEP received 120 Category 1 CME credits. Several eligible administrators are planning to sit for their American College of Medical Practice executive certification examination in February.

The second MEP, open to any physician or medical practice administrator, will begin March 24-25. The program will be limited to 36 participants. Watch your mail for a brochure and registration details. Or, for more information call Mary Reinsmoen, practice management coordinator, 800/728-5398 or 515/223-1401.

MEP December graduates are:

Julie Barto
Siouxland Women's Health
Center
Sioux City

Juanita Beal, RN
Neurological Center of Iowa
Des Moines

Bruce Bedell, MD
Medical Care Choices
Sioux City

Jim Burke, MD
Center for Family Medicine
Marshalltown

Denise Chaffee
Family Practice Center
Cedar Rapids

Pamela Clemons
Robert Clemons, Jr., MD
Boone

Teresa Dilts
Miller Orthopaedic
Council Bluffs

Beth Ehlers
Associates in OB and GYN
Mason City

Lee Fagre, MD
Family Health Center
Waverly

Angela Fuller, RN
Associated Medical Arts
Waterloo

Greg Harter, MD
Covenant Clinic
Waterloo

Barb Heck
IMS Services
West Des Moines

Denise Kaestner
North Liberty Family Health
Center
North Liberty

Sandra Kouba
Oncology Associates
Cedar Rapids

David Lemon, MD
Methodist Hospital
Des Moines

Robert Mason
Mercy Family Care Network
Mason City

Gerald McGowan, MD
Family Practice Residency
Training Program
Sioux City

Jay Mixdorf, MD
Mercy Family Care Network
Mason City

Thomas Pattee, DO
Covenant Clinic
Waterloo

Gary Peasley, MD
Marshalltown

Pam Robus
Pella Medical Center
Pella

Carol Roge, MD
Siouxland Medical Education
Foundation
Sioux City

Terrie Sandmire
Oto-Head & Neck Surgery
Des Moines

Jeanette Sargent
Physicians Clinic of West
Central Iowa
Carroll

Kim-Marie Schulze
Dermatology Clinic PC
Des Moines

Cindy Snedigar
Family Practice
of Washington
Washington

David Stilley, MD
Broadlawn Hospital
Des Moines

Marge Tully
WL Dull, MD, PC
Iowa City

Julie Warner
United Behavioral Systems
Des Moines

Duane Whitaker, MD
University of Iowa
Iowa City

GOOD REVIEWS FOR IMS MANAGEMENT EDUCATION PROGRAM (MEP)

"Health care economics could be a very boring topic but the speaker did an excellent job." Dr. Greg Harter.

"Best presentation on marketing I've seen. Excellent instructor, practical and humorous." Dr. Duane Whitaker.

"Outstanding and instructive. Lots of information, the time went fast." Marge Tully.

For more information on any seminar, call Mary Reinsmoen or Sherry Johnson at the IMS, 515/223-1401 or 800/728-5398.

ICD-9-CM Coding

A coding course stressing the rules and guidelines of ICD-9 Volumes 1 and 2 and applications to case studies.

CPT Coding

A coding course stressing the rules and guidelines of the CPT manual and application exercises.

ICD•9•CM and CPT Coding Combination

This seminar will offer 3 hours each of ICD•9 and CPT in a one day condensed version.

Wed., March 8
Wed., March 15
Thurs., March 16
Wed., March 22

Burlington Medical Center, Conference Room #4
Marian Medical Services, Classroom B, Sioux City
Marian Medical Services, Classroom B, Sioux City
St. Luke's Hospital, STL Resource Center Formal Lounge, Cedar Rapids
Marshalltown Medical & Surgical Center, Conference Room A

Tues., March 28

Presenter: **Mary Pat Wohlford-Wessels, MA, MS, RRA**, director of Health Care Administration, University of Osteopathic Medicine and Health Sciences, Des Moines.

Please bring Volumes 1 and 2 of your ICD•9•CM books.

Thurs., March 9
Wed., March 15
Thurs., March 16
Thurs., March 23

Burlington Medical Center, Conference Room #4
Marian Medical Services, Classroom C, Sioux City
Marian Medical Services, Classroom C, Sioux City
St. Luke's Hospital, STL Resource Center Formal Lounge, Cedar Rapids

Wed., March 29

Marshalltown Medical & Surgical Center, Conference Room A

Presenter: **Mary Reinsmoen**, coordinator of Practice Management, IMS Services, West Des Moines.

Please bring your 1995 CPT book.

Tues., March 21

IMS headquarters, Taylor Room, West Des Moines

Presenters: **Mary Pat Wohlford-Wessels, MA, MS, RRA**, director of Health Care Administration, University of Osteopathic Medicine and Health Sciences, Des Moines; and **Mary Reinsmoen**, coordinator of Practice Management, IMS Services, West Des Moines.

Please bring Volumes 1 and 2 of your ICD•9•CM books and your 1995 CPT book.

These all day seminars begin at 9:00 a.m. and end at 4:00 p.m. Lunch and breaks with refreshments will be provided.

The cost is \$150.00 for an IMS member or staff and \$240.00 for non-member or staff.

★ These programs are part of the IMS Medical Business Specialists (MBS) Certificate Program.

Registration Form

CPT _____

ICD9 _____

Combination _____

Name(s): _____

Clinic/Practice Name: _____

Address: _____

Phone: _____ Fax: _____

Amount Enclosed: _____ Date and Location: _____

Please make checks payable to IMS SERVICES. Mail check and registration form to:
IMS SERVICES ATTN: Sherry Johnson, 1001 Grand Avenue, West Des Moines, IA 50265-3599.

MIDWEST MEDICAL INSURANCE COMPANY FOCUS ON RISK MANAGEMENT

Informed consent

Informed consent is the result of an educational process between the physician and the patient. The physician's duty is to provide sufficient information to enable the patient to make an informed decision regarding treatment. The patient's role is to understand and evaluate the information and give actual consent to — or refuse — the treatment.

Explaining the risks and benefits of treatment options during the informed consent discussion can prevent confusion, improve patient compliance and reduce the chance of a lawsuit. A significant number of malpractice claims are precipitated by a patient's surprise over unexpected adverse outcomes and inadequate physician-patient communication.

Failure to disclose material risks is seldom a primary allegation in a malpractice claim.

However, it is a secondary element in many. To help minimize your liability risk:

- Distinguish a patient's written authorization for treatment (the form) from the informed consent (the process).

- Do not delegate the responsibility for obtaining informed consent — it is the physician's duty.

- Utilize patient education materials and audiovisual aids to help the patient understand.

- Document the informed consent discussion in the clinic medical record.

For further information, contact Lori Atkinson, MMIC risk management coordinator, MMIC West Des Moines office, PO Box 65790, West Des Moines, 50265, 800/798-9870 or 515/223-1482.

Reimbursement for DME

By January 1, 1996, suppliers of durable medical equipment (DME) will not be reimbursed for these items unless they have a Medicare supplier number. A supplier cannot obtain a supplier number without meeting Medicare-determined uniform national standards.

Suppliers may distribute to physicians or beneficiaries a certificate of medical necessity which contains no more than the following information provided by the supplier:

- An identification of the supplier and the beneficiary to whom such equipment or supplies are furnished.

- A description of the equipment/supplies.

- Any product code identifying the medical equipment or supplies.

- Any other administrative information (other than the information relating to the beneficiary's medical condition) prescribed by the Secretary.

The American Medical Association supported clarification of the Certificate of Medical Necessity requirements to allow the supplier to provide product information.


January issue of *Iowa Medicine*):

5. **Amount and/or Complexity of Data to be Reviewed:** change the next documentation guideline (the fourth one) to:

"Relevant findings from the review of old records and/or the receipt of additional history from the family, caretaker or other source should be documented. If there is no relevant information beyond that already obtained, that fact should be documented. A notation of 'old records reviewed' or 'additional history obtained from family' without elaboration is sufficient."

6. **Risk of Significant Complications, Morbidity and/or Mortality:** change the fourth documentation guideline to:

"The referral for or decision to perform a surgical or invasive diagnostic procedure on an urgent basis should be documented or implied."

7. **Table of Risk:** Under "presenting problems", in the High Level of risk category, add the word "may" to the second bullet, to read, "Acute or chronic illnesses or injuries that *may* pose a threat . . ." 

HCFA's E & M documentation guidelines are final and appeared in the Part B News Extra November 28.

HCFA E & M Code documentation

Since the IMS Services E & M coding seminars, there have been the following changes in the final guidelines (continued from

Newsmakers

AT A GLANCE

*Dr. Campbell Watts, Cedar Rapids general surgeon, has written the book *Defending the Breast Cancer Malpractice Case with Cedar Rapids trial lawyer, David Elderkin. This is the first book written jointly by members of the two professions.**

The Center for Family Medicine in Marshalltown and the Jefferson Clinic recently merged with McFarland Clinic. Including the Jefferson and Marshalltown locations, McFarland has offices in eight central Iowa communities.

On the manpower front, a \$50,000 bonus is being offered to two or three family practice or internal medicine specialists who are willing to team up with either one of two clinics or any solo practitioner in Maquoketa. The incentive is being offered by the Jackson County Public Hospital and would be spread over a five-year period.

Awards, appointments, etc.

Dr. Michael Emery was recently certified by the American Board of Plastic Surgery and became a member of the American Society of Plastic and Reconstructive Surgeons. Dr. Mary Kemm, Cedar Rapids anesthesiologist, was recognized at the YWCA's 13th annual Tribute to Women of Achievement, held at the Five Seasons Hotel, Cedar Rapids. Dr. William Galbraith, associate of internal medicine at the U. of I. College of Medicine, received the 1994 Internist of the Year Award from the Iowa Clinical Society of Internal Medicine. The award recognizes excellence in practice and community service. Dr. Linda Railsback, ob/gyn director at Broadlawns Medical Center in Des Moines, has been selected by the American Medical Women's Association (AMWA) to receive the 1994 Community Service Award. The award honors AMWA physicians from all over the country who have given outstanding volunteer service to their local communities. Dr. Donald Burrows, Des Moines pulmonary diseases and internal medicine specialist, has become an accredited clinical polysomnographer after passing the national examination by the American Board of Sleep Medicine. He is the only accredited polysomnographer in Des Moines and one of only three in Iowa. Dr. John Maksen, Des Moines, has become board certified in cytopathology by the American Board of Pathology. Dr. Yogesh Shah, Mount Ayr, is now providing obstetric care to Ringgold County. Obstetric care had not been available in the county since August 1992. St. Paul Fire and Marine Insurance Company's Medical Services division has instituted a program which allows retired volunteer physicians to continue to serve patients. The St. Paul's Retired Volunteer Physician program offers basic and affordable coverage for former physician professional liability policyholders of St. Paul. Dr. Craig Thompson, Strawberry Point family physician, was named Physician of the Year by the Iowa Osteopathic Medical Association. Dr. Donald Nelson, assistant director of Cedar Rapids Medi-

cal Education Program, was elected chairman of the American Society for Testing and Materials Committee, which is a technical standards writing committee on computerized systems. Dr. Monte Skaufle, director of the Mercy/St. Luke's Family Practice Residency Program in Davenport, was presented the Iowa Family Practice Educator of the Year award during the Iowa Academy of Family Physicians' 46th Annual Meeting and Scientific Assembly in Des Moines. At that same meeting, Dr. Kelly Ross, Saint Ansgar, was recently awarded the 1994 Iowa Family Doctor of the Year. Dr. Corrine Ganske has been named the associate director of the Family Practice Residency Program at Iowa Lutheran Hospital, Des Moines. Dr. Charles Davis, U. of I. associate professor of preventive medicine and environmental health, has been appointed to the editorial board of *Controlled Clinical Trials*, the official journal for the Society of Clinical Trials. Dr. Davis has also been appointed to a three-year term on the executive committee of the Biopharmaceutical Section of the American Statistical Association. Dr. Jon Lemke, U. of I. associate professor of preventive medicine and environmental health, has been elected to the governing board of the American Public Health Association.

New members (as of September 1994)

Des Moines

John Ankeny, DO, family practice, emergency medicine
 Majed Barazanji, MD, family practice
 Scott Carver, MD, family practice
 Robert Clark, Jr., MD, general surgery
 Philip Clevenger, DO, family practice
 Kevin Crowe, MD, cardiology
 Jeffrey Davieck, MD, orthopaedic surgery
 Karl Dignan, MD, diagnostic radiology
 John Eley, DO, resident
 Richard Evans, DO, general practice
 John Fell, DO, family practice
 Michael Hart, MD, otology, neurotology
 Robin Hartley, DO, family practice
 Calvin Hansen, MD, neurology

Kathleen Hansen, MD, pathology
 Christine Holm, MD, oncology
 Douglas Horsington, DO, otolaryngology
 Mark Jones, DO, general practice
 Kathleen Lange, MD, resident
 Kathryn Lynn, DO, internal medicine
 Brian Mehlhaus, MD, family practice
 Randy Maigaard, MD, internal medicine
 Eden Murad, DO, family practice
 Jeffrey Nichols, DO, anesthesiology
 Daphne Panagotacos, MD, dermatology
 Wesley Richardson, DO, psychiatry
 Catherine Rook-Roth, DO, family practice
 Pricilla Ruhe, MD, family practice
 David Sandercock, DO, resident
 Bryon Schaeffer, MD, resident
 Douglas Selover, DO, pediatrics
 Theresa Smith, MD, internal medicine
 Larry Standing, DO, family practice
 Jacqueline Stoken, DO, physical medicine and
 rehabilitation
 Susan Wilkinson, MD, infectious diseases

Dubuque

Joseph Compton, MD, internal medicine
 Joseph Jenkins, MD, general surgery
 Stephen Pierotti, MD, orthopaedics
 Thomas Schreiber, MD, family practice

Fort Madison

Mark Reynolds, MD, ophthalmology

Grimes

Douglas Layton, DO, family practice

Grinnell

Clayton Francis, MD, family practice
 Guy McCaw, MD, family practice

Indianola

Daniel Miller, DO, family practice
 Rene Staudacher, DO, family practice


Deceased members

Dallas Minchin, MD, 66, anesthesiology,
 Council Bluffs, died November 16

Paul, Stitt, MD, 80, life member, general
 surgery, Fort Dodge, died October 9

Joseph Weyer, MD, 86, life member, obstet-
 rics/gynecology, Fort Dodge, died October 25

Irving Hanssmann, MD, 88, life member,
 internal medicine, Council Bluffs, died July 23

Craig Ellyson, MD, 86, life member, family
 practice, Waterloo, died November 23 

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Domestic violence: the law and physician liabilities

Statistics and studies present staggering proof that domestic violence is a medical-legal issue of major proportions. Domestic violence almost always is an assault (physical, psychological or sexual) committed by male partners against women. Lest anyone believe domestic violence is an urban ill, the U.S. Department of Justice National Crime Victimization Survey concluded that women living in central cities, suburban areas and rural areas experience similar rates of violence by intimates.

It is estimated that between 20,000 and 44,000 Iowa women suffer abuse in their homes every year. Between 1990 and 1994, 33 Iowa women were murdered by husbands and boyfriends. The Iowa Judicial Department reports that the number of domestic abuse civil filings rose from 188 in 1990 to 2,677 in 1993 alone. Domestic violence projects in Iowa provided shelter to approximately 8,000 women and children in 1993.

In a way, domestic abuse is a silent epidemic. Of the women who were physically abused by their partners, 92% did not discuss the abuse with their physicians and 57% did not discuss the incident with anyone. A study of a family practice clinic in the Midwest revealed that 38.8% of the women respondents had been physically assaulted by their partners but only six of these women had been asked about domestic violence by their physician.

Iowa Legislature addresses domestic abuse

The medical and legal communities in Iowa have sought to respond to this crisis. In 1991, the Iowa Legislature passed comprehensive legislation addressing domestic abuse which 1) made it easier for victims to seek protective orders and provided for better notice of the protective order to law enforcement; 2) required hospitals to develop protocol for identifying and responding to the needs of domestic violence victims; and 3) emphasized the development of various programs for assisting victims.

In 1993, the Iowa Supreme Court established a Task Force on Courts' and Communities' Response to Domestic Abuse calling for a cooperative response by the courts and communities. The Task Force's final report set forth 76 recommendations, including exhortation to the medical community to participate in statewide and local community efforts. The Iowa Medical Society, the Iowa Hospital Association and the Iowa Coalition Against Domestic Violence developed domestic abuse protocol for use by hospital emergency room physicians and personnel. (These protocol are available to IMS member physicians by calling Becky Roorda at the IMS, 800/747-3070.)

Domestic abuse is a crime

Iowa law is unequivocal — domestic abuse is a crime. Depending upon the severity of



JEANINE FREEMAN, JD

Ms. Freeman practices with the firm of Dickinson, Mackaman, Tyler and Hagen, PC in Des Moines. She was formerly an attorney for the Iowa Hospital Association.



Professional ethics often require such involvement, with subsequent failure to do so posing the greater risk of legal liability.

the assault, domestic abuse is punishable as a simple, aggravated or serious misdemeanor. Iowa law does not distinguish in punishment between domestic and other situations involving the commission of sexual abuse, infliction of serious physical or mental harm, or homicidal acts.

It is important for physicians to recognize domestic abuse is a crime in order to understand their legal duties in reporting to law enforcement authorities. Physicians also have regulatory and professional responsibilities to cooperate with community service agencies in providing for victim safety. Physicians play a key role in identifying a patient as a victim of domestic abuse, in establishing intervention and treatment plans that reflect the unique care needs of victims and in referring the victim to law enforcement and community assistance agencies for support that is beyond the expertise of the medical community.

While physicians believe that greater involvement by them with victims of domestic violence enhances their exposure to legal liabilities, the law and professional ethics often require such involvement, with failure to do so posing the greater risk of liability.

Reporting to law enforcement agencies

Confusion has reigned regarding reporting responsibilities for domestic abuse under Iowa law. When the General Assembly passed its domestic abuse reform legislation in 1991, it specifically rejected mandatory reporting of all instances of domestic abuse to law enforcement by hospital emergency room personnel. That legislative judgment call was in accord with the view of victims' advocates as well as principles of medical ethics, emphasizing respect for patient autonomy and confidentiality. Victims will often forego medical treatment rather than run the risk of a filed report with law enforcement.

In 1993, the Iowa Legislature amended Iowa's law on reporting wounds of criminal violence to require reports of *gunshots, stab wounds or other serious bodily injuries* received in the course of the commission of a crime. As already noted, domestic abuse is a crime. This narrower approach to reporting is supported by victim advocates.

Iowa Code §147.111 and its reporting responsibilities apply directly to Iowa physicians. Commonly asked questions are:

- 1. Who must report?** Health care professionals who administer treatment (or from whom treatment is sought but not administered) to any person suffering a gunshot or stab wound or other serious bodily injury.
- 2. Under what circumstances should a report be filed?** Where it appears that the gunshot, stab wound or other serious bodily injury was incurred in connection with the commission of a crime. Serious bodily injury is a bodily injury which creates a substantial risk of death or which causes serious permanent disfigurement or protracted loss or impairment of the function of any bodily member or organ.
- 3. When and to whom should the report be made?** Required reports shall be made "at once but not later than 12 hours" after application for treatment was made or treatment was provided. Reports shall be made to the appropriate law enforcement agency where

REFERENCES

AVAILABLE
References for this article are available from the editors of Iowa Medicine.

**Any physician
failing to make a
required report
shall be guilty of
a simple
misdemeanor.**

treatment was provided or, if ascertainable, where the injury was received.

4. What must be reported? The report is simple: the person's name, the person's residence and a brief description of the gunshot, stab wound or other serious bodily injury.

5. Is patient consent required before a report is filed? So long as the report fits the definition of a required report under §147.111, patient consent is not necessary. The statute states "any provision of law or rule of evidence relative to confidential communications is suspended insofar as the provisions of this section are concerned." The AMA recommends the physician inform the patient of the legal responsibility to report, explain investigation and follow-up procedures and address the risk of reprisal and possible need for shelter.

6. Is reporting required only where the injured person presents at the hospital emergency room? The statute makes no distinctions between sites, and places the responsibility on the health care professional regardless of where the treatment is provided.

7. What happens if a physician fails to report? Any person failing to make a required report shall be guilty of a simple misdemeanor, punishable by imprisonment not to exceed 30 days or a fine of at least \$50 but not more than \$100. Also, a physician may incur legal liability if the physician fails to make a required report and the patient suffers further harm that could have been prevented if law enforcement had been notified *as required by law*.

8. What are the legal protections for making reports? The law does not provide specific legal protection from civil and criminal liability for filing good faith reports under this reporting requirement. In that regard, §147.111-.113 is different from Iowa's reporting laws on child and dependent adult abuse. Section 147.111 does, however, suspend confidentiality interests where a required report is made; this serves as legal protection to physicians filing reports that meet the definition of the statute.

9. Suppose a physician makes a report, believing in good faith that the injury met the requirements of the statute but, upon investigation, these conclusions are shown to be incorrect? *So long as the physician filed the report in good faith belief that the report was required or that other interests such as patient or physician/staff safety demanded protection and the report was not filed for improper motives, Iowa case law supports the physician's judgment call.*

10. Can a physician permissively report an injury other than those defined by §147.111? Generally, no. Unlike Iowa's reporting laws on child abuse and dependent adult abuse, this section of the Code does not specifically authorize permissive reporting without patient consent.

A physician who files a report of domestic abuse which falls outside the scope of required reporting under §147.111 without the patient's consent clearly runs a legal risk. There may be instances, however, in which a report to law enforcement is necessary to protect the *immediate* safety interests of the patient, the patient's family or the physician and the staff of the physician or hospital. *In such instances, confidentiality interests likely give way to immediate safety needs.* Any risk of liability for reporting in such an instance is clearly minimized if only information essential to the report is provided. Of course, a report is autho-



No provision is made for physician cooperation with law enforcement officials conducting an investigation based on the report.

ized if the patient has knowingly given consent to the filing of the report.

11. To what extent should a physician cooperate with a follow-up investigation by law enforcement officials? Again, unlike other Iowa mandatory reporting laws, no provision is made within §147.111-.113 for physician cooperation with law enforcement officials conducting an investigation based on the report. Furthermore, §147.111 suspends confidentiality requirements only for purposes of filing the required report and does not specifically relate to release of information in the course of investigation by law enforcement.

Law enforcement officials have no absolute right to medical information even where that information is necessary to investigate a crime. Interestingly, §147.112 specifically states that law enforcement authorities shall not divulge any information either received by them in a report made under §147.111 or gathered by them in a follow-up investigation except to other law enforcement officials and then only in connection with investigation of the alleged crime. This provision indicates a legislative intent to balance practitioner concerns with confidentiality — whether information is released via report or investigation — with the need for information.

The law in this area, however, is unclear and each situation presents a different measure of legal risk. *A physician is always best advised to release otherwise confidential information to investigative authorities only with patient authorization.* Any release of information without patient consent is done at legal risk. Some information may not be medical or treatment information and, therefore, not specifically governed by either confidentiality or privilege, but physicians are generally not in a position to make such judgment calls. Physicians should err on the side of confidentiality. If the victim refuses to consent to release of information to law enforcement, physicians are advised to release such information only pursuant to an order of a court, which, while cumbersome and time-consuming to investigators, protects physician and patient interests. If the patient has died, the legal risks in releasing information related to the matter under investigation are clearly minimized.

Reporting issues under Iowa law require judgment calls relative to the nature of the injury and other matters before a report is or is not filed. Physicians should document their decision to report or not report and their medical findings supporting that decision. Physicians must also be aware of hospital policies and protocols for reporting and abide by them. Physicians should advise their office staff regarding reporting in the event patients who are victims of domestic abuse present to the clinic or office setting.

Physician responsibilities under hospital protocol

As a result of the 1991 domestic abuse legislation, Iowa law and regulations of the Iowa Department of Inspections and Appeals require hospitals to have in place protocol for responding to the needs of domestic violence victims. These requirements are consistent with standards of the Joint Commission on Accreditation of Health Care Organizations (JCAHO). JCAHO and Iowa law focus on identification of patients who are victims of domestic violence, privacy in interviews, patient consent and confidentiality, information

A physician who fails to abide by recognized protocol could be held liable for not living up to what is now a duty, stated in law.

on community resources, preservation of evidence and record keeping.

Neither hospital licensure regulations nor JCAHO standards specifically apply to physicians, therefore physicians cannot be disciplined under them. However, medical staff rules and regulations generally require physician compliance with hospital policies. Physicians also operate at legal risk in failing to adhere by hospital policies and protocol where such failure ultimately results in harm to the patient. Physician coordination with hospital policy and protocol is essential.

Confidentiality — be cautious about disclosing information

Victims of domestic violence deserve the same level of physician-patient confidentiality as any other patient. The only specific Iowa statutory exception to confidentiality is for required reporting noted above. Physicians should be particularly cautious about disclosing information to a partner of the victim who could be the abuser. Regulations mandating hospital protocol provide for confidentiality of "the person's treatment and information", creating a wide berth for confidentiality and heightened possibilities of liability for failure to abide by confidentiality requirements.

Informed consent

Iowa law is firmly committed to informed consent for patient care. Physicians owe a general duty to disclose to their patients all information material to making an informed decision. Victims of domestic violence remain autonomous medical decision makers and may refuse treatment or intervention proposed by the physician. At the same time, part of assuring that the consent is informed may very well require that physicians address safety and other matters of concern that the victim might harbor regarding a suggested plan.

Physician duties to patients who are victims of domestic abuse

Physicians generally owe a duty to their patients to obtain informed consent and to provide care and treatment in accordance with recognized medical standards. Questions arise whether newly-developed legal, regulatory and professional emphasis on the physician's role in domestic abuse situations creates additional duties for physicians, breach of which may result in liability.

Potential liabilities arise within the context of patient care and negligence in not adhering to medical standards in providing such care. In the same way, a physician who fails to abide by recognized protocol for identification and referral of a patient as a victim of domestic violence could be held liable for not living up to what now is a duty stated in law and regulation and which, arguably, has been a long-standing professional responsibility.

Physicians are best protected from the risk of legal liability by familiarizing themselves with applicable protocol and adhering to them, by providing necessary medical care, by providing information to victims regarding legal and community assistance, by respecting patient autonomy and confidentiality and by making required reports. Physicians should

HERE'S TO YOUR

Health

A patient's guide to better health
Provided by the Iowa Medical Society

Domestic Abuse *an information & referral guide for battered partners*



A letter to battered women

Unfortunately, violence is a part of many women's lives. If you are being abused, you are not alone. Millions of women are battered by their partner. If you are unsure whether you are being abused, ask yourself if your partner's behavior includes any of the following:

- pushing, shoving, slapping, hitting, kicking, choking, throwing objects at you
- put-downs, name-calling, accusations, mind games
- destroying property, threatening your children
- threatening suicide, threatening to report you to the authorities
- controlling all the money, not allowing you enough money for family or personal expenses, preventing you from getting a job
- forcing sex against your will, physically attacking the sexual parts of your body, accusations that you are having sex with another partner

Abusive behavior usually increases in frequency and severity over time. Remember, the abuse is not your fault. Violence is used to gain, maintain and regain power and control. It is used to lower your self-esteem and limit your resources so you don't feel you can safely leave the abuser. (See pages 2 and 3 of this insert for safety planning ideas you may want to consider if you are planning to leave the abuser.)

There are resources and options available to assist you in getting away from the violence. For information regarding shelter services, counseling, support groups, court advocacy and safety planning call the Iowa Domestic Abuse Hotline, 1-800/942-0333. All contacts with any domestic violence project will be kept confidential.

You know what is best for yourself and your children. Use the skills and resources you have to leave the violence when you are ready. No one deserves to be abused.

Laurie Schipper



The Iowa Medical Society's most important and long-standing goal is protecting the health of Iowans through a variety of projects and activities. IMS members play a significant role in formulating policy and publishing educational materials on key public health issues such as tobacco use, rural health care and domestic abuse.

What is domestic violence or abuse?

Domestic violence is physical, emotional or sexual abuse that occurs between two people who are, or were, in an intimate relationship (spouse, ex-spouse, lover or dating partner). It is a pattern of abusive behavior used to control one's partner. Refer to page 1 for some examples of abusive behavior. Other abusive behavior includes:

- isolating you from friends or family
- controlling who you spend time with and where you go
- trying to keep you from driving by tampering with your car
- forcing your car off the road or trying to run you over
- displaying weapons in a threatening way
- threatening to kidnap the children if you leave
- threatening to kill you

Who is to blame for the violence?

Domestic abuse is a learned response. Many abusers grew up witnessing abuse or were abused themselves. However, this does not excuse their behavior. Battering is a conscious choice the batterer makes as a way to control another person because it is effective. Domestic violence is not a mental illness, nor is it caused by substance abuse—although this may intensify it. The abused person is not responsible for her abuser's violent behavior. Part of the abuser's plan is to lower his partner's self-esteem so he can blame her for the abuse: "You make me beat you by how you act. You deserve to be hit because you make me mad."

What can a woman do to stop the violence?

In most cases, the only thing you can do to stop the abuse is to leave the relationship. Yet, there are risks in fleeing from the abuser. Each woman must decide what is best for herself and her children. Remember, the abuse is not the victim's fault.

If a woman is planning to leave her abusive partner, what preparations should she make?

Following are safety planning ideas a battered woman may want to consider:

- Save and hide money.
- Make an extra set of house, car, safety deposit box and other keys. Keep them in a safe place, such as a friend's

house or at a domestic shelter.

- Hide extra clothes for yourself and your children at a friend's house or another safe place.
- Keep any evidence of physical abuse (ripped clothes, photos of bruises and injuries, etc.).
- Make and hide a file of important documents such as restraining or no-contact orders, birth certificates, bank records, school records, insurance papers, food stamps or AFDC papers, medical records, prescriptions, phone numbers and all Social Security numbers.
- Start talking to people about the abuse—a trustworthy friend, a shelter staff person, your family doctor, minister or lawyer.
- Practice calling 911 and crisis lines; practice driving to the police station.
- Teach your children which neighbor to go to and how to call for help.
- Back the car into the driveway so you can get away faster. Keep only the driver's door unlocked.
- Learn to know the coming signs of violence. How long does it take him to escalate?
- Start doing things like walking the dog or taking out the trash at odd hours. If an escape is necessary, pretend you're leaving to walk the dog and get out. Drive or walk to a friend's house, a shelter or police station.
- Arrange a signal with a neighbor; for example if the porch light is on, call the police.

Will I lose custody of my children if I leave without them?

No. The fact that you had to flee for your safety does not mean you do not care about your children. But, if you are forced to leave them behind, be sure to see a lawyer immediately. The police and your local shelter can also be helpful. Keep in mind that the longer you leave your children, the harder it may be to get them back.

Are children affected by partner battering?

The appearance of violence and cruelty threatens the child's sense of safety as well as provokes fears for the safety of his parents. When physical violence occurs, it results in a dramatic increase in the child's fears. A child who watches a parent being injured frequently develops symptoms typical of depression, like crying spells and regresses to behaviors such as bed wetting, thumb sucking and withdrawal. A child who witnesses the abuse of a

Feelings and defenses of battered women



parent over the long term frequently develops problems with loyalty, initially aligning himself with the abused parent and later identifying with the abuser. A child may take the position that daddy beat up mommy because "mommy deserves it." Also, a common side effect of chronic domestic violence in the home is abusive and controlling behavior by the child.

Is battering a crime under current law?

Yes. Any act intended to cause you pain or injury, or which is intended to place you in fear of immediate physical contact, or which involves pointing a firearm toward you or displaying a dangerous weapon in a threatening manner is a crime. You need not have visible injuries or broken bones to call for police protection.

Law enforcement officers must now use all reasonable means to prevent future abuse, including arranging to take you to a safe place or a medical facility or remain with you until the threat of violence ends. An officer must arrest your abuser when there is reason to believe you have been hurt or someone intended to seriously injure you or has displayed a dangerous weapon in a threatening manner. Also, if the person assaulting you is in violation of an order issued by the court, the officer must make an arrest.

If I have a friend who is being battered, how can I help her?

Your role as helper should be to provide support, assistance and information without judging. Be ready to listen, but don't pry for details. Keep things told to you in confidence, confidential. Direct responsibility for the violence onto the batterer, not your friend. She does not deserve to be hurt regardless of the choices she's made. Be nonjudgemental, even if you think she has made some foolish choices.

You may wish to help your battered friend explore options, but don't make decisions for her. Help her plan a safe escape from her home by gathering the things described on pages 2 and 3 of this brochure. Assist her in contacting the Iowa Domestic Abuse Hotline (1-800/942-0333) or a local shelter.

This information on domestic abuse has been compiled from publications of the Iowa Coalition Against Domestic Violence, Children & Families of Iowa, Family Resources, Inc. and the Iowa Medical Society. As a service to IMS member physicians, this insert may be photocopied for placement in clinic reception areas. Original inserts may be purchased from the IMS for 15 cents each. Call Jane Nieland or Bev Corron at the IMS, 515/223-1401 or 800/747-3070.



**Accurate
documentation can
be an invaluable
source of
protection against
claims of
legal liability.**

document all of these matters in patient records. Special considerations also come into play in treating victims of domestic violence, such as taking proper steps to insure patient safety. Common sense judgment premised on the patient's best interests goes a long way to minimizing legal liabilities.

Physician's duty to warn third parties

Physicians sometimes question whether they will be held liable for injuries that occur once a domestic abuse victim leaves their care and is again subjected to abuse. Iowa courts have determined that a person generally owes no duty to control the conduct of others unless a special relationship between them creates such a duty. A relationship giving rise to a duty of care is necessarily based on the foreseeability of harm to the injured person.

It is not inconceivable that legal action could be brought naming the physician and alleging some legal duty to have warned law enforcement authorities or some other third party regarding potential harm to the patient or to another. To date, Iowa case law has not been quick to find such a duty, particularly where physicians act reasonably, in good faith, in accordance with legal and regulatory requirements and consistent with standards of care. Again, knowledge of and compliance with applicable protocol and documentation are key to avoiding legal liabilities in this arena.

Documentation

Department of Inspections and Appeals rules for hospital protocol on domestic abuse require that treatment records of domestic abuse victims include assessment information, proof the victim was informed of telephone numbers for community assistance, medical care information, notations regarding follow-up care and the victim's statement of how the injury was received.

Physician documentation should be consistent with these hospital requirements. In addition, physicians should note whether a report to law enforcement was made and whether such a report was made as required by Iowa Code §147.111, or because of concern for patient safety or the safety of others, or with patient authorization. Greater detail should be provided where a report outside of §147.111 and without patient consent is made. Accurate documentation can be an invaluable source of protection against claims of legal liability.

Physician involvement is crucial

The American Medical Association, the Iowa Legislature and a range of public and private policy agencies are strongly encouraging (if not requiring) physician involvement in identification of and assistance to domestic violence victims. Focus on patient care needs, compliance with medical standards, adherence to the requirements of reporting laws and regulatory protocol and accurate documentation are the best protections for physicians in avoiding liabilities as they become essential partners in providing support services to victims of domestic violence. ■

AUTHOR'S NOTE

This article is informational and is not an exhaustive study of all matters of potential legal liability arising from working with victims of domestic abuse. Physicians with specific questions should consult legal counsel.

Documenting domestic abuse

Proper documentation of known or suspected domestic abuse requires careful observation and interview techniques. It will take extra time and effort and special insight, but cutting corners might later prove to be a critical mistake.

The physician's duties and liabilities must always be considered when documenting cases of abuse. Medical records of the treatment given to a patient may prove to be crucial evidence in a court of civil or criminal law. Your report might provide the evidence necessary to prevent further violence.

Because domestic violence can be very complex, specialized training is invaluable. Without it, subtle indicators may be missed, resulting in an inaccurate diagnosis. Staff at local domestic violence projects are usually happy to present information regarding the dynamics of domestic abuse at little or no cost. Understanding the patient's special needs will enable the medical professional to be more effective, especially during the interview.

Multiple barriers often exist for professionals conducting interviews of domestic abuse victims. The patient might be overwhelmed with fear and shame. A victim's behavior can be misunderstood. The best, single piece of advice is this: *Be willing to ask about the abuse or suspected abuse in a caring, non-judgmental fashion.*

There are many indicators of abuse and, if any are noted, inquire about them. Even if the patient is reluctant or unwilling to cooperate, chances are she will be glad you asked, despite how it may appear from her outward reaction. Any time you suspect domestic violence, refer the patient to the nearest domestic violence project and document the fact that you made the referral. These projects often have available brochures or other information for patients. (See page 81 for a list of domestic violence projects around Iowa.)

It is vitally important to avoid responding negatively to the victim. If a victim is "revictimized" in your office, the chances of conducting a productive interview and beginning the



CURTIS RUBY

Mr. Ruby has been a police officer in Fort Dodge for 15 years. He serves on the Crime Victim Assistance Board of Iowa and is a former board member and co-chair of the Domestic/Sexual Assault Outreach Center public awareness committee.

MEDICAL RECORD DOCUMENTATION

Thorough medical records are essential for preventing further abuse and provide evidence which may prove crucial to the outcome of a case. If medical records and testimony at trial conflict, the record may be considered more credible. Records should include:

• **Complete medical and social history.**

• **Detailed description of the injuries including type, number, size, location, resolution, possible causes and explanations given. Where applicable, record the location and nature of the injuries on a body chart or drawing.**

a. Bruises or burns that have a pattern characteristic of the object used.

b. Bite marks, scratches, missing clumps of hair.

c. Ligature marks, fingerprints about the neck.

d. Lacerations, especially defense type wounds to hands and arms.

• **Chief complaint and description of the abusive event, including a**

detailed history of the events leading up to presentation at the hospital. Use the patient's own words whenever possible rather than your own assessment: "My husband hit me with his fist" rather than "Patient has been abused".

• **An opinion on whether the injuries were adequately explained.**

• **Results of all pertinent laboratory and other diagnostic procedures.**

• **Color photos and imaging studies, if applicable.**

• **If the police are called, the name of the investigating officer and any actions taken.**



process of emotional healing are jeopardized. Hypersensitivity is a reality with any trauma and physicians should expect absolute professionalism from their staff. Victims are not usually readily recognized as such and are often not at their best when seeking assistance.

It is important to consider carefully the questions and comments put to a domestic violence victim. A question such as 'Why do you tolerate this?' is judgmental because it implies you believe she has a choice and is somehow responsible. Asking why the patient waited to seek treatment sends the same accusatory message. It is almost impossible to avoid some mistakes during an interview, but the impact is lessened if your approach is sincere and respectful. Following are suggested questions:

- "I suspect that family violence is a problem here. Are you in a safe relationship?"
- "What happens when you and your partner have a fight or disagree?"
- "I'm concerned about your safety. How can I help?"
- "Do you or your children ever feel afraid of your partner?"

Suggestions for documentation are:

- Document in every case, whether or not the police are contacted. If there is police involvement, be sure to include the name of the investigating officer in the report.
- Whether or not the police are called, handle the case as if the records might someday be part of an investigation. Disfigurement, disabling injury, feticide, sexual abuse, kidnapping, related child abuse, homicide and suicide far too often occur with domestic violence.
- Photographs should be routine in these cases, but keep in mind this can only be done with the patient's written consent. The same applies if searching for further indicators of abuse using imaging studies. Photographs should be properly dated, marked and handled in the most confidential manner possible.

Complete documentation and successful intervention depends on the physician's willingness to take time to explore the patient's needs. Documenting abuse cases involves careful observations combined with non-judgmental interviewing techniques. Interview the victim alone, out of earshot of the partner who may be the abuser.

Injuries can be hidden by makeup, clothing or hair and the truth may be concealed by lies and half-truths. However, the motives are the same — fear, shame and lack of trust. The physician may prove to be the only hope for a victim of domestic violence. The well-prepared medical record may later be the key to the patient's safety and future. ■

PHYSICIAN TESTIMONY

According to the AMA, for medical records to be admissible in court, the doctor should be prepared to testify:

- That the records were made during the "regular course of business" at the time of the examination or interview.
- That the records were made in accordance with routinely followed procedures.
- That the records have been properly stored and their access limited to professional staff.

EDITOR'S NOTE

Content, opinions and instructions in this article are those of the author and should not be interpreted as reflecting the approval, disapproval, policy or opinion of the Fort Dodge Police Department or any section or officer thereof.

TAKING PHOTOGRAPHS OF DOMESTIC ABUSE INJURIES

Photographs may be taken with the patient's permission. Hospital protocol may require that patients sign a consent form.

- | | |
|---|---|
| <ul style="list-style-type: none"> • The photographer should be the same sex as the patient, if possible. • Take photos before medical treatment is given, if possible. • Include the patient's face in at least one picture (or, the patient's hand holding an identifying document). • Use color film. • Mark photographs precisely as soon as possible with the patient's | <ul style="list-style-type: none"> name, the date, time and photographer's name. Consider using a quality instant camera so photos can be marked immediately. • Photograph from different angles, full body and close up. • Take at least two pictures of every major trauma area. • Use a ruler or other object to illustrate the size of the injury. • Photographs should be kept in a sealed envelope with the written statement 'Confidential . . . to be used only by patient'. |
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Rural battered women

Battered women in rural Iowa often believe that, even if they were to escape the violence, there would be no one to help and no place to hide from their abuser. The rural experience presents some unique barriers for battered women and service providers.

The experience of many battered women in rural Iowa

There are several key issues that isolate rural battered women:

- Many rural battered women may not have access to a telephone. If they do have phone service, many calls may be long distance and, therefore, easily tracked by the abuser.
- There is usually no access to public transportation. This means the woman must rely on the family vehicle. If there is a vehicle available, batterers often damage it or make sure it is out of gas.
- Due to geographical proximity, police and medical response may not be timely enough to assist many rural battered women. It may also be true in some rural areas that law enforcement, attorneys and judges have not had adequate training in domestic violence. This can result in inadequate intervention.
- Resources available to help battered women who escape their homes are often limited. For example, there are few jobs available in rural areas, poor housing and there may be limited child care, social services and health care.
- Access to the court system can be limited in rural Iowa. In some areas, women must wait for up to two weeks to get an emergency order for protection because a district court judge is only in the area once every two weeks. Women are often forced to travel across several counties with their children to seek protection from the court.
- Extreme weather conditions may further exacerbate the isolation or the woman's ability to escape or seek support.
- Hunting weapons are normal part of farm life. There may be a shot gun or rifle — seldom registered — in the house, barn or truck. Batterers may also have easy access to farm tools such as axes, saws and chains and may use them to abuse their partner.
- Travel to a larger city may be an additional crisis for a rural battered woman. She may feel intimidated and unable to cope with a city which appears uncaring or unaccepting.
- Bruises and other injuries sustained by rural battered women may heal before they are seen by neighbors, family or professionals. Farm machinery may also provide an easy excuse for injuries which are actually a result of abuse.
- Rural women are often financially dependent on farm income and may have no financial resources of their own. Often, rural battered women must decide between leaving and risking the family farm or staying and enduring the abuse.
- Restraining orders are often modified to allow the batterer access to the farm as his only source of income.



LAURIE SCHIPPER
Ms. Schipper is executive director of the Iowa Coalition Against Domestic Violence.



Other barriers for rural women

An additional barrier for rural women is the severe lack of available domestic violence services. Domestic violence projects in rural areas often serve a five to 10 county area. With severely limited financial resources and staff, the distances they must cover put a serious strain on these projects.

It is often difficult to ensure confidentiality for battered women in rural areas. It is common for a woman seeking assistance to find that the domestic violence advocate meeting her at the hospital is also her children's Sunday school teacher or that the police officer responding to her call is one of her husband's friends. This makes it more difficult to provide confidentiality regarding delivery of services and the location of shelters or safe homes.

Many of us have been socialized to view families as private and this is especially true for rural families who value privacy and rarely seek outside assistance other than from extended family members. We also have a belief that country life is somehow safer than city life. Attitudes to the contrary may be met with resistance and ridicule.

It should be noted that rural battered women do escape the violence and go on to live a violence-free life. However, it is often a difficult and dangerous path. Battered women need options and resources to assist them with keeping safe and getting out. (For more information on services available across Iowa, including a map, see page 80 of this issue.)

RURAL EXPERIENCE by Lydia Walker

(published by the National Coalition Against Domestic Violence Rural Task Force)

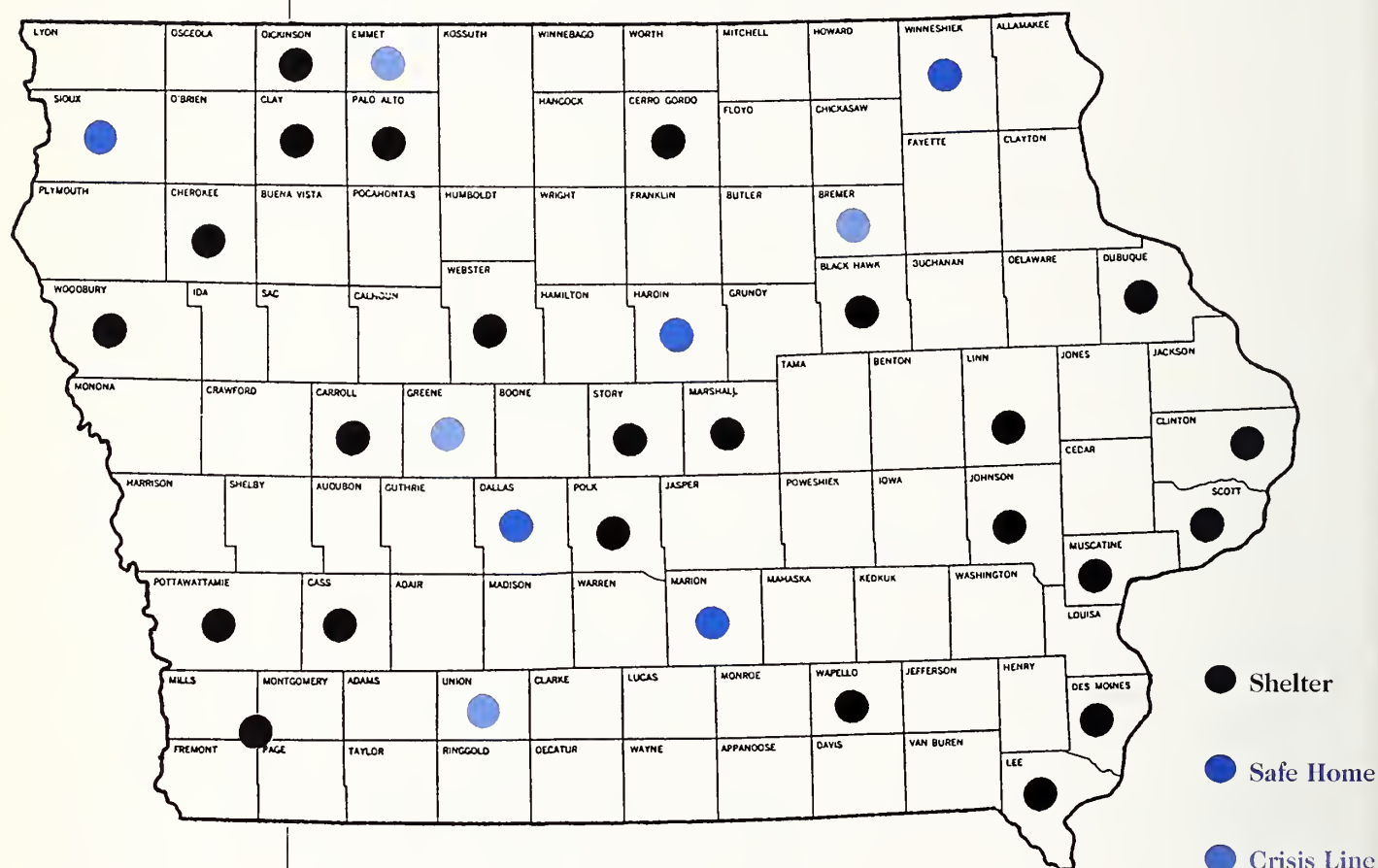
It's really
just as you imagine.
The woman
dragging and carrying
two children
is panting as she stumbles
along the deer trail
that leads down back behind
the neighbors.
Inside, with slow deliberation
he is pulling on his boots
and finding the flashlight
and finally,
when she does hear him coming
he is moving much faster
than they can go.
In town,
he catches her again on the way to
the discount store,
and four counties buzz
about the power of the hunting rifle that
blew clean through.
Three of us from the shelter
drive an hour to go over,
and at the funeral,
a man reads the survivors:
first sons, then daughters;
father, then mother;
brothers, sisters;

paternal, then maternal
grandfathers, grandmothers.
The first man to view the body
wears a shiny crimson red windbreaker
with a Taxorback Hog smarling
across his back,
and even some of the pall bearers
don't wear suit coats — the family is so poor.
But many women have already dropped by
plates of food
to offer hospitality to those
who stop by or call,
and the funeral director's wife
has put a display of
china cups and china saucers
near the registry.
The woman's quartet, accompanied by a
slide steel guitar, sings
"Just Inside the Eastern Gate"
and that does seem nice
because she loved country music.
I think it really must be the same — wife beating
— in the city or the country.
For me, personally,
I can't tell the difference in
the horror of screaming
and no one coming to help
and the horror of screaming
and no one hearing at all.

**Often, rural
battered women
must decide
between leaving
and risking the
family farm or
staying and
enduring the abuse.**

Domestic violence programs

The map below shows the locations of domestic violence shelters, safe homes and crisis lines throughout the state. For more complete information regarding specific services offered by each program, call Chris Clark of the IMS staff, 800/747-3070.



Referral information

According to the Iowa Coalition Against Domestic Violence, the mission of domestic violence centers in Iowa is to provide information, resources and advocacy to battered women to help them make the best choices for themselves and their children. The centers are committed to helping women in a way and in a time frame that feels comfortable to them. The battered woman is the expert on how she can stay safe and alive.

If you are working with a woman who has been battered or who you suspect has been battered, give her good information about what resources are available in her community to help. Remember, not all battered women will be ready to seek assistance at the time of referral. This does not mean the referral process was unsuccessful. Many battered women use the information at a much later date when they feel strong enough to seek assistance.

DID YOU MISS LAST MONTH'S MAGAZINE?

The January *Iowa Medicine* was also dedicated to domestic violence. If you missed it or didn't get your copy, call IMS headquarters.



Domestic violence center staff must follow Iowa Code Section 236A on confidentiality. Staff is not allowed to release information regarding any woman with whom they are working unless they have written permission from the woman to release specific information to a specific person. This means even after you have referred a woman to a shelter, you may not receive follow-up information on her whereabouts or safety. This can be frustrating for referring physicians and for shelter staff. However, it is important to remember that in many cases confidentiality keeps battered women and children safe while they seek help.

Below are the hotline numbers for domestic abuse projects in counties across Iowa.

PROJECT	NUMBER	COUNTIES SERVED
Adel	800/400-4884	Dallas, Madison
Ames	800/203-3488	Boone, Greene, Hamilton, Hardin, Story
Atlantic	800/696-5123	Adair, Adams, S. Audubon, Cass, Shelby, E. Pottawattamie
Burlington	319/752-4475	Des Moines, Henry, Lee, Louisa
Carroll	800/383-9744	Carroll, Crawford
Cedar Rapids	319/363-2093	Benton, Jones, Linn
Cherokee	800/225-7233	Buena Vista, Cherokee, Ida, Sac
Clinton	319/243-7867	Clinton, Jackson
Council Bluffs	712/328-0266	Harrison, Pottawattamie, Shelby
Creston	515/782-6632	Adair, Adams, Clarke, Decatur, Ringgold, Taylor, Union
Davenport	319/326-9191	Scott, Rock Island (Illinois)
Decorah	800/383-2988	Alamakee, Buchanan, Chickasaw, Clayton, Fayette, Howard, Winneshiek
Des Moines	800/942-0333	Polk
Dubuque	319/588-4016	Clayton, Delaware, Dubuque
Eldora	515/858-2618	Franklin, Grundy, Hardin
Estherville	712/362-4612	Clay, Dickenson, Emmet, Palo Alto
Fort Dodge	515/573-8000	Calhoun, Hamilton, Humbolt, Pocahontas, Webster, Wright
Iowa City	800/373-1043	Cedar, Iowa, Johnson, Washington
Jefferson	515/386-4056	Greene
Keokuk	319/524-4445	Lee, Clark (Missouri), Hancock (Illinois)
Malvern	800/468-7333	Fremont, Mills, Montgomery, Page
Marshalltown	800/779-3512	Jasper, Marshall, Poweshiek, Tama
Mason City	800/479-9071	Cerro Gordo, Floyd, Franklin, Hancock, Kossuth, Mitchell, Winnebago, Worth
Muscatine	319/263-8080	Muscatine
Ottumwa	800/464-8340	Appanoose, Davis, Jefferson, Keokuk, Lee, Mahaska, Monroe, Van Buren, Wapello, Wayne
Pella	800/433-7233	Marion, Warren
Sioux Center	800/382-5603	Lyon, O'Brien, Osceola, Plymouth, Sioux
Sioux City	800/982-7233	Woodbury, Monona, Plymouth, parts of Dakota (Nebraska), Union (South Dakota)
Waterloo	319/233-8484	Black Hawk
Waverly	800/410-7233	Bremer, Butler
STATEWIDE DOMESTIC ABUSE HOTLINE		800/942-0333

If you have a reception area full of patients, let her know you are concerned about what she has told you and ask her to schedule another appointment to discuss it.

What works, what doesn't

You can accomplish much in a short time — “Educate yourself about this complex problem and beware of the assumption that most victims of partner battering present in the emergency room. Even if you have a reception area full of patients, don't be afraid to question a patient about possible abuse. If the woman admits she has been abused, let her know you are very concerned about what she has told you and ask her to schedule another appointment so you can discuss it with her. Finally, develop a relationship with the people in your local community who are trained and equipped to assist victims of domestic violence. Don't feel you have to handle the problem alone.” **REBECCA WIESE, MD, DAVENPORT FAMILY PHYSICIAN AND CHAIR OF THE IOWA MEDICAL SOCIETY'S TASK FORCE ON DOMESTIC VIOLENCE.**

Let them know you care — “Patients usually want to tell someone, but they won't tell just anyone. They won't share confidences with someone who appears intolerant or uncaring. The most important thing is to be kind, non-threatening and non-judgmental when you suspect a patient is living in an abusive situation. It is imperative to let them know you care and that you will help them if they want help. Patients find it much easier to discuss these problems if they understand that many other people have been in similar situations and that there are many people willing to help.” **LEE FAGRE, MD, WAVERLY FAMILY PHYSICIAN.**

Ask and ask again — “Keep an open mind and keep the possibility of abuse in your mind at all times. Don't be blinded by a patient's socioeconomic status. Many of us have a bias that this doesn't go on in the upper classes. Don't be afraid to keep asking. Some women might admit it the twelfth time you ask. Even then, she may not be ready to seek help. Remember there are agencies that will be very helpful. Become familiar with the services offered by your local domestic violence shelter.” **JOHN ANKENY, DO, DES MOINES EMERGENCY ROOM PHYSICIAN.**

A special program for victims — “Each year, the tragedy of domestic violence affects over five million American women from all socioeconomic, religious and racial backgrounds. Many abusers attack the victim's face with their hands, a knife, cigarettes or other weapons in an effort to retain control and keep other men away. Victims often do not seek medical assistance for injuries which are not life-threatening such as broken noses, bruises, small lacerations or burns.

“The lack of initial treatment of these injuries can lead to facial disfigurement from scarring and poor healing, as well as deformity from the poorly healed bone injuries. For example, a malar tripod fracture, septal hematoma or nasal bone fracture may not be readily apparent because of overlying swelling or the lack of significant symptoms, so the patient avoids treatment. Once the swelling resolves and the tissues contract, dramatic deformities

Look on page 80 of this issue for a map of Iowa domestic abuse shelters and complete information on services offered locally around Iowa.



may result and may further lower the victim's self-esteem.

"Because many victims may not have insurance or finances to pay for correcting this damage, the American Academy of Facial Plastic and Reconstructive Surgery started the National Domestic Violence Project. This program provides free consultation and surgery to victims of domestic violence, thus alleviating some of the pain and psychological injury to these victims.

"The toll-free project number is 800/842-4546. A call to this number will provide names of surgeons in the victim's area who will provide free consultation and perform free surgery if needed. Perhaps this will help some women break out of the cycle of violence, enhance their self-esteem and help them rebuild their lives." JEFFREY CARITHERS, MD, DES MOINES FACIAL PLASTIC SURGEON.

Myths and realities

Myth: Family violence is most prevalent among the lower class.

Reality: Family violence occurs at all levels of society and without regard to age, race, cultural status, education or religion. It may be less evident among the affluent because they can find and afford private physicians, attorneys, counselors and shelters. Individuals with fewer financial resources turn to more public agencies for help.

Myth: Abused spouses can end the violence by divorcing the abuser.

Reality: According to the U.S. Department of Justice, about 75% of all spousal attacks occur between people who are separated or divorced. Separation often brings on an increased level of harassment and violence.

Myth: The victim can learn to stop doing things that provoke the violence.

Reality: In a battering relationship, the abuser needs no provocation to become violent. Violence is the abuser's pattern of behavior and the victim can't learn how to control it. Even so, many victims blame

themselves for the abuse. Friends, family and service providers reinforce this by laying blame and the need to change on the victim's shoulders.

Myth: Alcohol, stress and mental illness are major causes of physical and verbal abuse.

Reality: Abusive people — and even their victims — often use those conditions to excuse or minimize the abuse. But, abuse is a learned behavior not an uncontrollable reaction. People are abusive because they've acquired the belief that violence and aggression are acceptable and effective responses to real or imagined threats. Fortunately, abusers can benefit from counseling.

Myth: Being pregnant protects a woman from battering.

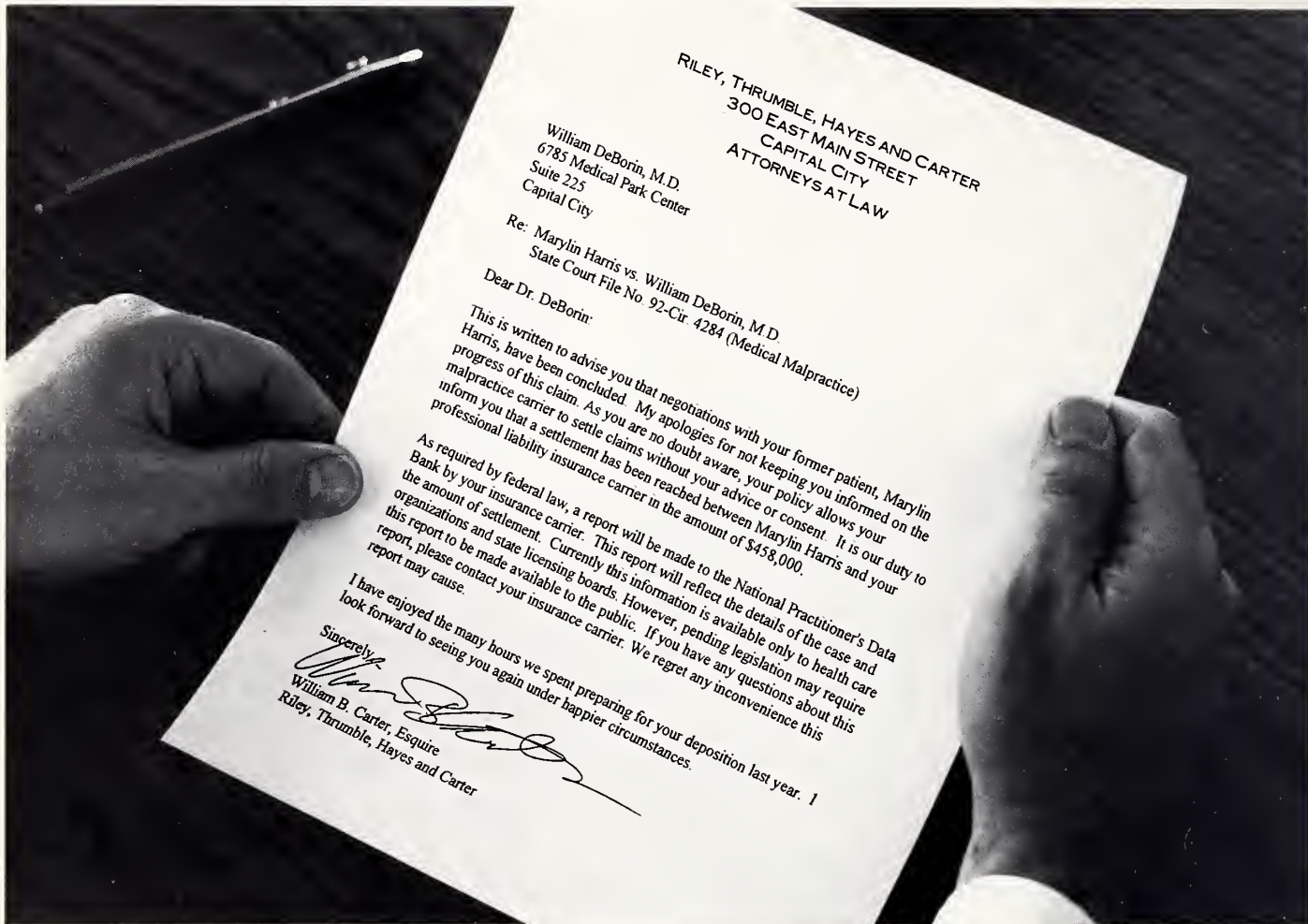
Reality: Battering frequently begins or escalates during pregnancy. **IM**

About 75% of all spousal attacks occur between people who are separated or divorced.

PHYSICIAN SURVEY

If you haven't already done so, please complete the physician survey on domestic violence which appeared in last month's *Iowa Medicine* and return it to IMS headquarters. This survey will help us determine future educational efforts. If you misplaced your survey, call Bev Corron at the IMS, 800/747-3070 for another copy.

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The Journal

of the Iowa Medical Society

Iowa domestic abuse scenarios

● LEE FAGRE, MD; KATHILEEN BUCKWALTER, RN

Editor's note: The following cases are in response to a request by the Iowa Medical Society's Domestic Violence Task Force for domestic violence scenarios. Cases 1, 2 and 3 were submitted by Dr. Lee Fagre. Case 4 was submitted by Kathleen Buckwalter.

Case 1

A 26-year-old G3P1SAb1 married white female normally cared for by one of your partners presents with diffuse abdominal pain not associated with cramping, vaginal discharge or bleeding. Opening her chart you note she is 20 weeks pregnant and had an uneventful pregnancy up until one month ago when she was seen in the emergency room with similar symptoms. Findings were negative and her tenderness disappeared over the next two weeks. The patient is very concerned she is going to lose the baby like she did during her last pregnancy. Physical exam reveals a diffuse tenderness over the abdomen with a soft uterus and fetal heart tones which are reassuring at 152bpm. The sterile speculum exam reveals a closed os with no bleeding or rupture of membranes.

You should next:

- 1) Assure her everything is okay, send her home and have her come back to see her regular doctor tomorrow.
- 2) Order an ultrasound to rule out abruptio.
- 3) Set her up for a non-stress test.
- 4) Ask her questions from your domestic violence screening questionnaire.

While there are no specific right answers there are a few wrong answers. The patient is only 20 weeks and is not far enough along for a non-stress test. Reassuring her everything is okay should be done as well as an ultrasound at some point. However one of the first

things the physician should do is clarify whether this is a domestic violence situation and make sure the mother is safe from future harm. Family stressors are at a high level during pregnancy and it is a common time for violent situations to arise.

Case 2

A 35-year-old married white female presents to the emergency room late one night with alcohol on her breath and a painful right jaw. Her husband brought her in and hovers at her bedside listening closely to your exchange with his wife. She states she fell down the stairs to the basement and can't open her jaw. Physical exam reveals a contusion over the right mandible with tenderness at the TMJ. The patient is unable to open her jaw more than a centimeter and has a malocclusion when asked to bite.

You should next:

- 1) Ask her questions from your domestic violence questionnaire while she is in the emergency room.
- 2) Get x-rays of her jaw.
- 3) Call in a social worker because you suspect domestic violence.
- 4) Call the police saying you suspect domestic violence and you're not sure what the husband will do when/if he is confronted.
- 5) Follow the patient to x-ray and ask your domestic violence questions at that time.

The presence of the husband in the emergency room makes questioning the patient difficult. Concern for a potentially violent situation should make the physician request the presence of the police in the emergency room. A good way to separate the husband and wife is to take her back to x-ray and ask her questions at that time. In this case the

The IMS Education Fund has designated this article as the Henry Albert Scientific Presentation Award for February 1995.

LEE FAGRE, MD

Dr. Fagre is a family practitioner in Waverly.

KATHILEEN

BUCKWALTER, RN

Ms. Buckwalter is a professor at the College of Nursing, University of Iowa, Iowa City.

Iowa domestic abuse scenarios

continued

patient confided that her husband had beaten her, but she refused to file charges and refused any counseling with a crisis worker. Had this happened now instead of five years ago the physician could contact the local law enforcement agency. A no contact order could be issued regardless of whether or not the patient files charges if the physician and the judge deem the patient is in danger.

Case 3

A 28-year-old married female who works on your office clerical staff comes in Monday morning with a black eye. She states she and her husband, who is a well respected young business man, were at a football game over the weekend where a drunken spectator elbowed her in the eye. You check her over and pronounce her fine, but you notice she needs a tetanus. On pulling up the sleeve to give her a Td you see several ecchymosis on her upper arm in the shape of a hand grasping the arm and squeezing.

You should next:

- 1) Accuse her of lying and tell her to come out with the truth.
- 2) Give her the Td injection, note your findings in her chart for future reference and ask her to set up a complete physical tomorrow.
- 3) Check some blood clotting studies.
- 4) Ask her to come to your office and question her about domestic violence.

In this case, which happened several years ago, other office staff had known her husband had been beating her, but were unable to convince her to do anything about it. The topic was even more taboo at the time of this case than it is now and it was only with time and several attempts at intervention that we were able to convince her she was not at fault.

Case 4

Mr. Smith is a 70-year-old man suffering from Alzheimer's disease who has been cared for by his wife for 10 years. One day while their seven-year-old granddaughter was visiting, Mr. Smith suddenly and without warning, approached his granddaughter from behind and hit her in the back with his fist. When Mrs. Smith heard of her husband's unpro-

voked behavior she slapped him across the face as hard as she could. She confided this incident to Dr. Marcus Welby when she accompanied her husband for an examination. Mrs. Smith continued by saying "You can report me if you want. I wanted him to know just exactly how my granddaughter felt when he hit her. My husband always hits those who are weaker than himself. You wouldn't believe what I've had to put up with during our marriage."

You should next (choose as many as you like):

- 1) Explore Mrs. Smith's statements — "My husband always hits those who are weaker than himself. You wouldn't believe what I've had to put up with during our marriage."
- 2) Refer Mrs. Smith to a licensed psychologist for therapy.
- 3) Recommend placement for Mr. Smith in a long-term care facility.
- 4) Report Mrs. Smith for dependent adult abuse.
- 5) Provide information on community resources and agencies (e.g., Alzheimer's support group, adult day care center).
- 6) Provide instruction in behavior management for persons with Alzheimer's disease.

This may have been Mrs. Smith's attempt at asking for help. Dr. Welby explored the situation further. This was the first time Mrs. Smith hit her husband. She felt he had been manipulative throughout their marriage and although had been a "good provider," he had difficulty expressing love. He had never physically abused her, but had been "mean" to their two sons and occasionally hit them. Despite these circumstances, Mrs. Smith expressed affection for her husband and wanted to continue to care for him in their home. Dr. Welby provided instruction in behavior management and gave Mrs. Smith a list of community resources. Mrs. Smith began attending an Alzheimer's support group and utilizing an adult day care center which allowed her more time for recreational activities. The next time Dr. Welby visited Mrs. Smith she expressed more confidence in her caregiving role and a greater satisfaction with her life in general. **IM**

Laparoscopic splenectomy

● WARREN BOWER, MD; DAVID COSTER, MD; VICTOR WILSON, MD; MARK WESTBERG, MD

The application of laparoscopic techniques to general surgical procedures has revolutionized modern surgical care. With continued advancement in instrumentation, the majority of common surgical procedures will be done with minimally invasive techniques.

There is already widespread application in gynecologic, biliary, urologic and gastrointestinal surgery for procedures such as pelvic exploration, uterine myomectomy, ovarian cystectomy, cholecystectomy, common bile duct exploration and stone removal, pelvic node dissection and appendectomy.

Other procedures are being done as well but are less widespread. These include vagotomy, pyloroplasty, Nissen fundoplication, colon and small intestine resection, nephrectomy, adrenalectomy and others.

The benefits of decreased recovery time, less pain, decreased cost, shorter hospitalization times, fewer medication requirements and increased patient satisfaction are obvious for some procedures, less so for others. We applied advanced laparoscopic techniques for the removal of the spleen, a procedure not commonly done laparoscopically, with excellent outcome.

Case Report

A 40-year-old white female was referred for idiopathic thrombocytopenic purpura (ITP) with failure to respond to medical treatment with prednisone. Her initial platelet count was 38,000 when first diagnosed. Her complaint was an upper respiratory infection and easy bruising. Her health was otherwise marred only by hypertension, for which she took hydrochlorothiazide and Tenoretic® (atenolol and chlorthalidone). Her physical examination, aside from multiple bruises and moderate obesity, was unremarkable. She had good

response to initial treatment, with platelet count rising to normal with prednisone therapy. However, once her prednisone was tapered to a dosage of 20mg per day, her platelet count dropped to 2000 and she developed spontaneous bruising again. Her prednisone was increased to 60mg per day with a return of the platelet count to 238,000 and she was scheduled for splenectomy.

After routine, electrocardiogram, chest x-ray, blood chemistries, complete physical for medical clearance, and intramuscular Pneumovax, the patient was prepared for surgery. There she was given a general anesthetic and placed in a supine position with the legs apart, thighs level with the abdomen. A nasogastric tube and foley catheter were placed. Six trocar sites were selected, and all trocars were inserted under direct vision after the abdomen had been insufflated with CO₂ (Figure 1).

The patient was placed in extreme reverse trendelenberg and rotated to the right. The stomach was retracted to the right with a Babcock clamp and the spleen was identified. The splenocolic ligament was divided and the lower pole of the spleen mobilized. The short gastric vessels were then identified, clipped and divided, progressing cephalad until all were freed. The superior peritoneal attach-

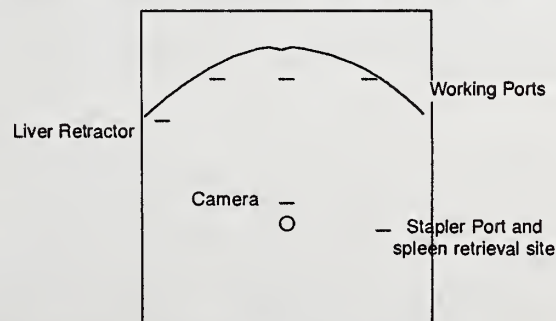


Figure 1. Port placement for the six trocar technique of laparoscopic splenectomy.

WARREN BOWER, MD
DAVID COSTER, MD
VICTOR WILSON, MD
MARK WESTBERG, MD

Drs. Bower, Coster and Wilson are general surgeons practicing as Surgical Associates in Grinnell. Dr. Westberg is a hematologist/oncologist at Iowa Methodist Medical Center, Des Moines.

Laparoscopic splenectomy

continued

ments to the spleen were divided and the spleen was free on its pedicle. We placed an Endo-GIA stapler with a vascular cartridge across the splenic hilum to divide the spleen completely from its main blood supply. It was placed in a plastic bag and brought out through a slight enlargement of the trocar site in the left lower quadrant. The entire procedure took less than two hours.

The patient had a nasogastric tube in place for 24 hours, was placed on full liquids and advanced to a regular diet by the following day. Pain was minimal. She was discharged from the hospital 48 hours after surgery with a normal platelet count on a tapering dose of prednisone. She returned to normal activity within 10 days.

Discussion

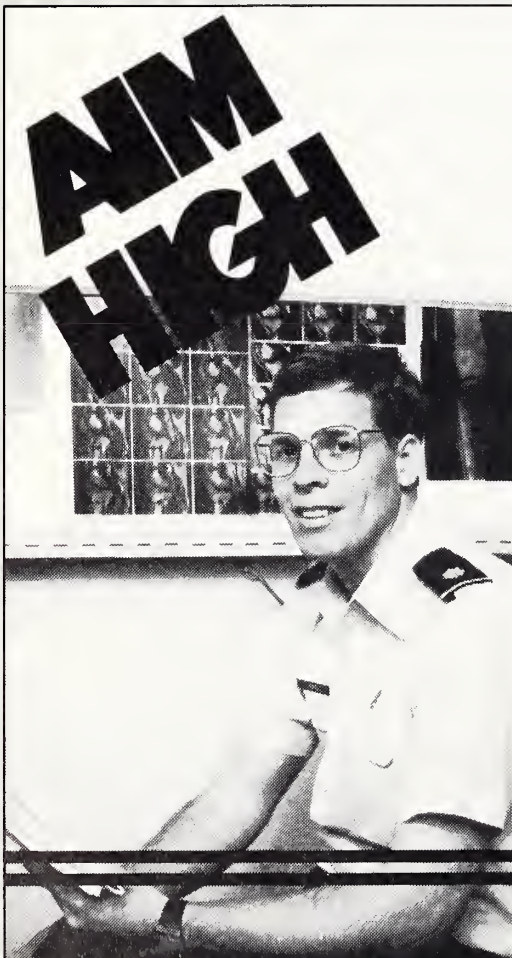
Laparoscopic splenectomy has been performed successfully for staging of Hodgkins disease, ITP, Hereditary Spherocytosis and warm antibody hemolytic anemia.¹⁻³ The pitfalls of the laparoscopic technique have been

identified and are easily avoided with proper technique. The laparoscopic splenectomy can be done safely and has the added advantages of decreased length of hospital stay, less patient discomfort, earlier return to regular activity and decreased cost. It is applicable to most patients who require splenectomy for the usual medical indications.

It probably is not appropriate or feasible for splenomegaly due to the technical limitations caused by the size of the spleen and it is unlikely to be useful in unstable trauma patients. Those two exceptions aside, this new approach to splenectomy is likely to become the gold standard of the future.

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3. Carroll, BJ: *et al*: Laproscopic splenectomy. *Surg Endo* 1992;6:183-85. **IM**



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Family life can be beautiful

Domestic violence is the major topic again in this issue of *Iowa Medicine*. It is unfortunate because happiness and love will bind a family with everlasting ties that carry through adversity as well as with the pleasant times. Cultural characteristics often are denominators in the relationships between family members. Familial examples and experiences may enter into the patterns of violence. If the cultural mores of a family "dictate" a major dominance of male over female, violence appears "accepted" without moral or legal recourse. But, such should not be.

The peoples of the United States are of diverse origins. The "melting-pot" of cultures within our society presents different attitudes as well as language. I have a concern about that.


Our governmental bodies seem bent on providing multilingual environments. Non-English speaking children are to be taught in their native language; documents are to be prepared in various languages. Past generations of immigrants who became part of our society found it necessary to learn the English language. Their mother tongue was reserved for their home, family and acquaintances of the same culture.

Based on the premise that we must preserve the mother tongue in their new country, are we to preserve their family behavior also? If strong paternal dominance with violent overt behavior is acceptable in their country of origin, are we to accept such here?

Violence has been a part of human behavior from centuries past: political violence, religious violence, as well as narrow and broad social violence. There are always the dominant and the oppressed. Yet, in recent years there has been an increase in known domestic violence. Is this a true increase or a reflection of recognition of the obvious?

As I compose these comments for publication, I reflect upon my own experiences. I come from a pure German background. My grandparents used the English language in public; German in the home. My parents were as fluent in Plattdeutsch as in English. They assimilated into the ways of life in Nebraska. Though there was paternal dominance in my family, there was no violence.

Though there was paternal dominance in my family, there was no violence.

My parents celebrated over 50 years of marriage. On Christmas Day, Jeannette and I celebrated our golden wedding anniversary and they have been golden years. Sure, there have been difficult times, but the happy days with four children and their families with eight grandchildren have been a blessing. Life is too dear, sacred and beautiful to be blemished with domestic violence. Why do humans have such a difficult time learning the beauty to be found in tranquility? Let us hope the future has more peace, love and happiness. Wouldn't that be great! 



MARION ALBERTS, MD

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The continuum of medical education

Milestones in medical education are familiar to all physicians. The first milestone is acceptance into medical school. Other milestones follow in sequence: completion of the preclinical coursework; clerkships; graduation; graduate residency training; licensure; and the initiation of practice.

Although it is logical to consider each of these milestones as a distinct event, the milestones are not discontinuous. They represent points in time in the continuum of medical education.

What may be discontinuous about this process is that there is a perception that medical education is linear and not circular.

With a linear perception we view medical education as an aging process. The young and uninitiated (medical students) gain knowledge, acquire judgement and skills (especially as residents) then apply their education in the community (as practitioners). The practice of medicine, fortified by continuing education, proceeds through the lifetime of the physician.

It is obvious to most physicians, however, that their abilities, especially the integration of knowledge and skill with experience, continue to develop long after the milestone of residency has transpired. The mid-career physician should be at the peak of professional competence.

Our educational institutions rely on these phenomena to educate the next generation of physicians. The ignorant and inexperienced are matched with the knowledgeable and wise.

The educational process acquires a circular continuum, the mid-career physician educating the neophyte student who eventually replicates the process with the next generation of students.

Of course the educational dynamic does not require the separation of teacher and student to be measured in decades. The second year medical student is often the tutor of the first year student; the resident is the counselor for the student.

An expanding challenge awaits educators as the emphasis in medical education now moves toward ambulatory education in the primary care disciplines.

Of necessity a larger portion of this education will occur in community settings where primary medical care is provided. The cadre of

physician-educators will be expanded, drawing on the interest and experience of community physicians.

There is no more powerful motivator to the experienced physician to remain current than an inquisition by a youthful student. The circle becomes complete. **IM**



RICHARD NELSON, MD

There is a perception that medical education is linear and not circular.

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Outstanding opportunity in emergency medicine for primary care trained or experienced emergency physicians. Samaritan Health Systems is a 275-bed hospital located in Clinton, Iowa. 14,000 annual volume/12-hour shifts. Samaritan Health Systems medical staff consists of 70 physicians representing a comprehensive range of medical/surgical specialties. This Mississippi riverfront community offers a variety of leisure activities, affordable housing and top-notch schools. An outstanding compensation package includes guaranteed minimum compensation, and health/dental, life, disability, malpractice insurances. **Send CV or call Sheila Jorgensen, Emergency Practice Associates, P.O. Box 1260, Waterloo, Iowa 50704; 800/458-5003.**

Family Practice, Carroll, Iowa—Outstanding professional opportunity for family practice physicians in a progressive, safe and clean community of 10,000. These opportunities are available for either experienced family practice physicians, or the family practice physician just beginning practice. Excellent schools (Catholic and public), quality hospital and significant income potential available. For more information, call Randy Simmons, Vice President, at 1-800/382-4197 or write St. Anthony Regional Hospital, South Clark Street, Carroll, Iowa 51401.

(Continued next page)

Advertising Rates and Data

Regular classified advertising sells for \$2.00 per line with a \$30 minimum per insertion. For members of the Iowa Medical Society the rate is \$20 per insertion. Display classified advertising sells for \$25 per column inch, per month. Sizes range from 1 column by 2 inches to 1 column by 6 inches. A variety of type sizes, borders, reverses or screens can be included in the ad. Blind box numbers are available upon request at no additional charge. Copy deadline is the 1st of the month preceding publication. Send or fax copy to Iowa Medicine, 1001 Grand Avenue, West Des Moines, Iowa 50265-3599, fax 515/223-8420.

Sioux City—An excellent position is available for a BC/BE family practice physician in a new community health center. A full range of family practice medicine is needed in a community that is very supportive of the center. Sioux City is a great place to raise a family and has excellent public and parochial school systems, a community college, 2 liberal arts colleges, a graduate center, 2 excellent medical centers, a Residency Training Program (family practice), etc. The center offers a competitive compensation and benefit package, paid malpractice, etc. FEDERAL LOAN REPAYMENT PROGRAM AVAILABLE. For more information write Jeff Hackett, Executive Director, Siouxland Community Health Center, 1709 Pierce Street, Sioux City, Iowa 51105 or call 712/252-2477.

Emergency Medicine, Des Moines, Iowa—Opportunity to join an established emergency medicine practice at Iowa Lutheran, member of the Iowa Health System. BE/BC in emergency medicine or primary care specialty with experience. Call me to learn more about our department and generous compensation package. Contact Larry J. Baker, DO, FACEP, 700 E. University, Des Moines, Iowa 50316; 515/263-5263.

Not Just Another Recruitment Ad—Opportunities at North Memorial-owned and affiliated clinics will give you a shot of adrenaline because we practice in a care management environment that FPs, IMs and OB/GYNs thrive on. Guide your patients through their entire care process at one of our 25 clinics in urban or semi-rural Minneapolis locations. Plus, become eligible for \$15,000 on start date. Interested BC/BE MDs, call 1/800-275-4790 or fax CV to 612/520-1564.

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and diverse school system, and many amenities for an excellent quality of life. Madison, WI, Dubuque, IA, and Rockford, IL, are just an hour away, while Chicago and Milwaukee are within an easy two-hour drive. When you're thinking about a setting for your professional practice and the "good life" for your family, give some thought to Monroe.

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AB/MO-11/94

Professional Listing

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1212 Pleasant, Suite 106
Des Moines 50309
515/243-0590

Allergy & Immunology

Allergy Institute, PC
A.Y. Al-Shash, MD
R.K. Agarwal, MD
1701 22nd Street, Suite 201
West Des Moines 50266
515/223-8622

Pediatric and Adult Allergy, PC
Veljko K. Zivkovich, MD
Robert A. Colman, MD
1212 Pleasant, Suite 110
Des Moines 50309
515/244-7229

Asthma, Allergy & Immunology

Dermatology

Robert J. Barry, MD
1030 Fifth Avenue, SE
Cedar Rapids 52403
319/366-7541
*Practice Limited to Disease,
Cancer and Surgery of Skin*

Fort Dodge Medical Center, PC
Carey A. Bligard, MD, FAAD
James D. Bunker, MD, FAAD
800 Kenyon Road
Fort Dodge 50501
515/574-6850

Electrodiagnosis

John Milner-Brage, MD
208 St. Francis Professional Building
Waterloo 50702
319/234-6446
*Electromyography & Nerve
Conduction Studies
Certified by American Board of
Electrodiagnostic Medicine*

Emergency Medicine

Acute Care, Inc.
P.O. Box 515
Ankeny 50021
515/964-2772 or 1-800/729-7813
*Comprehensive Emergency Medicine
Practice, Locum Tenens,
Doctor on Call*

Emergency Practice Associates
P.O. Box 1260
Waterloo 50704
1-800/458-5003
*Specialists in Emergency
Staffing & Emergency Department Services*

Family Practice

Acute Care, Inc.
P.O. Box 515
Ankeny 50021
515/964-2772 or 1-800/729-7813
*Locum Tenens
Doctor on Call*

Infectious Diseases

**Chest, Infectious Diseases & Critical Care
Associates, PC**
Daniel H. Gervick, MD
Daniel J. Schroeder, MD
Ravi K. Venuri, MD
Infectious Diseases
1601 NW 114th, Suite 347
Des Moines 50325-7072
24 Hours 515/224-1777

Infertility

Mid-Iowa Fertility, PC
Donald C. Young, DO
3408 Woodland Avenue, Suite 302
West Des Moines 50266
515/222-3060
*Reproductive Endocrinology/Infertility
IVF and GIFT Procedures
Donor Oocyte Program
Artificial Inseminations
Reproductive Surgery
Menopause Management*

Internal Medicine

Fort Dodge Medical Center, PC
Cardiology
Samir G. Artoul, MD, FICC
515/574-6840
Gastroenterology
Kenneth W. Adams, DO, AOBIM
General Internal Medicine
William C. Robb, MD
Richard H. Brandt, MD, ABIM
Grace Z. Ang, MD
800 Kenyon Road
Fort Dodge 50501
515/574-6820

Neurology

Iowa Medical Clinic Neurology
Andrew C. Peterson, MD
Laurence S. Krain, MD
600 7th Street SE
Cedar Rapids 52401
319/398-1721
*Neurology, EEG, EMG, Evoked Potentials
and Sleep Studies*

Fort Dodge Medical Center, PC
Jugal T. Raval, MD, MBBS
800 Kenyon Road
Fort Dodge 50501
515/574-6845

Neurosurgery

**Iowa Medical Clinic
Neurosurgery**
James R. Lamorgese, MD
600 7th Street, SE
Cedar Rapids 52401
319/366-0481
Practice limited to Neurosurgery

Hosung Chung, MD
2710 St. Francis Drive, Suite 401
Waterloo 50702
319/232-8756; fax 319/232-5703
Practice limited to Neurosurgery

Neurosurgical Services LLP

Robert Hayne, MD
Thomas A. Carlstrom, MD
David J. Boarini, MD
 1215 Pleasant, Suite 608
 Des Moines 50309
 515/241-5760

Robert C. Jones, MD
S. Randy Winston, MD
Douglas R. Koontz, MD
 2600 Grand Avenue, Suite 210
 Des Moines 50312
 515/283-2217
Neurological Surgery

Chad D. Abernathey, MD
 1953 1st Avenue SE
 Cedar Rapids 52402
 319/363-4622
Neurological Surgery

Obstetrics/Gynecology

Fort Dodge Medical Center, PC
Brian L. Weleh, MD
 800 Kenyon Road
 Fort Dodge 50501
 515/574-6870

Ophthalmology

Wolfe Clinic, PC
Russell H. Watt, MD
John M. Graether, MD
Gilbert W. Harris, MD
James A. Davison, MD
Norman F. Woodlief, MD
Erie W. Bligard, MD
David D. Saggau, MD
Steven C. Johnson, MD
Todd W. Gothard, MD
 309 East Church
 Marshalltown 50158
 515/754-6200

Satellite Offices
 Lakeview Medical Park
 6000 University Avenue, Suite 300
 West Des Moines 50266
 515/223-8685
 804 South Kenyon Road, Suite 100
 Fort Dodge 50501
 515/576-7777

Sartori Professional Building
 516 South Division Street
 Cedar Falls 50613
 319/277-0103

214 - 13th Street Southeast
 Cedar Rapids 52403
 319/362-8032

Ophthalmic Associates, PC
Robert D. Whinery, MD
Stephen H. Wolkstein, MD
Robert B. Goffstein, MD
Lyse S. Strnad, MD
 540 E. Jefferson, Suite 201
 Iowa City 52245
 319/338-3623

North Iowa Eye Clinic, PC
Addison W. Brown, Jr., MD
Michael L. Long, MD
Bradley L. Isaak, MD
Randall S. Brenton, MD
James L. Dummert, MD
 3121 4th Street, S.W.
 P.O. Box 1877
 Mason City 50401
 515/423-8861

Timothy F. Moran, Jr., MD
 United Federal Building
 700 4th Street, Suite 305
 Sioux City 51101
 712/252-4333

Satellite Clinics
 Horn Memorial Hospital
 700 E. 2nd Street
 Ida Grove 51445
 712/364-3311

Orange City Hospital
 400 Central Avenue NW
 Orange City 51041
 712/737-2426
General Ophthalmology

Orthopaedics

Iowa Orthopaedic Center, PC
Marvin H. Dubansky, MD
Marshall Flapan, MD
Sinesio Misol, MD
Joshua D. Kimelman, DO
Timothy G. Kenney, MD
Lynn M. Lindaman, MD
Jeffrey M. Farber, MD
Kyle S. Galles, MD
Scott A. Meyer, MD
Cassim M. Igram, MD
Donna J. Bahls, MD
Jill R. Meilahn, DO
Jacqueline M. Stoken, DO
 411 Laurel, Suite 3300
 Des Moines 50314
 515/247-8400

Orthopaedic Surgery

Fort Dodge Medical Center, PC
C. Mark Race, MD
 800 Kenyon Road
 Fort Dodge 50501
 515/574-6880

Otolaryngology

Iowa ENT, PC
Thomas A. Eriksen, MD
Marshall C. Greiman, MD
Steven R. Herwig, DO
Thomas O. Paulson, MD
Mark K. Zlab, MD
 1-800/248-4443
 1215 Pleasant, Suite 408
 Des Moines 50309
 515/241-5780

1200 35th Street, Suite 200
 West Des Moines 50266
 515/225-7761
Satellite Clinics:
*Pella, Perry, Newton, Indianola,
 Oskaloosa, Guthrie Center, Lakeview
 Medical Park-West Des Moines*

Wolfe Clinic, PC
Michael W. Hill, MD
Daniel J. Blum, MD
 309 East Church
 Marshalltown 50158
 515/752-1566

Lakeview Medical Park
 6000 University Avenue, Suite 310
 West Des Moines 50266
 515/224-9533

Sartori Professional Building
 516 South Division Street
 Cedar Falls 50613
 319/277-3105
*Otolaryngology-Head and Neck Surgery,
 Facial Plastic Surgery, Allergy*

Phillip A. Linquist, DO, PC
 1000 Illinois
 Des Moines 50314
 515/244-5225

*Ear, Nose and Throat Surgery,
 Facial Plastic Surgery, Head
 and Neck Surgery*

(Continued next page)

Professional Listing Rates

Physician members of the Iowa Medical Society may advertise in this directory. Monthly rates are as follows: \$10.00 first 3 lines; \$2.00 each additional line. Billed yearly. May be prorated. Send or fax copy to Iowa Medical Society, 1001 Grand Avenue, West Des Moines, Iowa 50265-3599, fax 515/223-8420.

Iowa Head and Neck Associates, PC

Robert T. Brown, MD
Eugene Peterson, MD
Richard B. Merrick, MD
Peter V. Bosen, MD
Robert R. Updegraff, MD
 3901 Ingersoll
 Des Moines 50312
 515/274-9135

Dubuque Otolaryngology-Head & Neck Surgery, PC

Thomas J. Benda, Sr., MD
James W. White, MD
Craig C. Herther, MD
Thomas J. Benda, Jr., MD
 310 North Grandview Avenue
 Dubuque 52001
 319/588-0506

Otologic Medical Services, PC

Roger A. Simpson, MD
Guy E. McFarland, MD
Thomas F. Viner, MD
Douglas E. Dawson, MD
 540 E. Jefferson, Suite 401
 Iowa City 52245
 319/351-5680
 1-800/642-6217
Maxillofacial, Plastic, Head & Neck Surgery

Robert G. Smits, MD, PC

1040 5th Avenue
 Des Moines 50314
 515/244-8152
 1-800/622-0002
*Ear, Nose and Throat Surgery,
 Facial Plastic Surgery and Head and Neck Surgery*

Pain Management**Iowa Medical Clinic Outpatient Pain Treatment Center**

James R. LaMorgese, MD, FACS,
Neurosurgeon, Medical Director
Sandra Gannon, LSW, ACSW, Program Director
 600 7th Street SE
 Cedar Rapids 52401
 319/399-2013
Neurology, Psychiatry, Anesthesiology, Rheumatology

Perinatology**Des Moines Perinatal Center, PC**

Neil T. Mandsager, MD
 3408 Woodland Avenue, Suite 302
 West Des Moines 50266
 515/222-3060
*Maternal-Fetal Medicine
 Routine and Advanced (Level II)
 Obstetric Ultrasound
 Genetic Counseling
 Amniocentesis and CVS
 Antenatal Testing
 High-Risk Obstetrical Management
 High-Risk Deliveries*

Physical Medicine & Rehabilitation**Genesis Regional Rehabilitation Center**

Genesis Medical Center
 1227 East Rusholme Street
 Davenport 52803
 319/383-1466
Maurice D. Schnell, MD
Fareeduddin Ahmed, MD
Arthur B. Searle, MD
Bogdan E. Krysztofiak, MD

Rehabilitation Medicine Associates

William D. deGravelles, Jr., MD
Charles F. Denhart, MD
Marvin M. Hurd, MD
William C. Koenig, Jr., MD
Karen Kienker, MD
Todd C. Troll, MD
Lori A. Sapp, MD
Yonker Rehabilitation Center
Iowa Methodist Medical Center
 1200 Pleasant
 Des Moines 50308
 515/241-6434

2600 Grand Avenue, Suite 102
 Des Moines 50312
 515/283-1570

Pulmonary Medicine**Fort Dodge Medical Center, PC**

Robert C. Ang, MD, FCCP
 800 Kenyon Road
 Fort Dodge 50501
 515/574-6820

Chest, Infections Diseases & Critical Care Associates, PC

Roger T. Liu, MD
Steven G. Berry, MD
Donald L. Burrows, MD
Michael Witte, DO
Gerard A. Matysik, DO
 1601 NW 114th, Suite 347
 Des Moines 50325-7072
 24 Hour 515/224-1777
Pulmonary Diseases

Surgery**Wendell Downing, MD**

1212 Pleasant Street, Suite 410
 Des Moines 50309
 515/241-5767
Diseases and Surgery of the Colon and Rectum

Fort Dodge Medical Center, PC

Ralph E. Woodard, MD, FACS
Dan P. Warlick, MD, FACS
 800 Kenyon Road
 Fort Dodge 50501
 515/574-6865

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Exciting times

These are exciting times. Communities are pursuing dramatically different ways of providing health care. In my own community, the revolution actually began in the late 1980s and what happened here demonstrates the forces of change working to reshape our practices.

Labor and management were on the downhill course in Dubuque and two work stoppages were in effect. A poll of the two sides indicated health care and health care costs were at the top of both group's concerns. The Tri-State Health CARE Coalition was formed in 1991 by a labor-management coalition to try and find a basis for cooperation. Two physicians were among the early participants. The mission of this group has changed since the beginning, but meetings are still held about once a month. The group's purpose has become preparing for the future of health care.

The Tri-State Health CARE coalition received a grant to establish a health care vision for the Tri-State area and explore the feasibility of a health care purchasing cooperative. The Coalition's revised vision statement clearly demonstrates the group's pledge to be a force for change: "The Tri-State Health CARE Coalition and its stockholders will use partnership approaches to fundamentally transform the region's medical care delivery/financing system from today's fragmented, costly, acute care oriented, responsibility shifting arrangements to a system founded on af-

fordable area wide coverage for all citizens who self assume responsibilities, and most importantly where health—not illness—is the norm! The mission of the organization is to be the lead organization in attaining the region's vision."

There is a noticeable shift in the way health care is paid for. The emphasis is moving toward wage increases for employees instead of health care benefits. The idea is to get people more involved in their own care and get them thinking about leading healthy lifestyles.

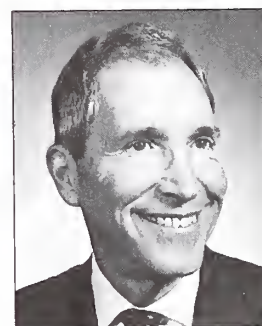
The idea for health insurance purchasing cooperatives came about because small employers are having difficulty obtaining affordable coverage for employees. The Iowa Legislature has created guidelines for buyers of health care services to organize to negotiate price and

quality with sellers of health care benefits. Sellers may be insurers, managed care organizations or other structures including physician organizations.

The Dubuque Coalition has studied a Rockford, Illinois plan whereby a group of companies hire local physicians to provide all pri-

mary care for their employees and specialty care is paid under traditional medical plans. A national program, Healthy 2000 has been initiated in Dubuque through the CARE coalition. The Tri-State Health CARE coalition is meeting now with provider groups every two weeks.

As I said, these are exciting times. Have you looked to see if you should be taking part? **IM**



JAMES WHITE, MD

**The emphasis
is moving
toward wage
increases
instead of health
care benefits.**

Join Us!

WHO ARE WE?

The Iowa Medical Group Management Association is a nonprofit organization whose membership is comprised of individuals engaged in the administrative aspects of medical group practice. Our membership is diverse, representing group practices operating under various organizational and financial structures. Current membership in IMGMA includes over 500 people representing almost 3,500 physicians.

WHO CAN BELONG?

There are four classifications of members: active, affiliate, honorary and life. Active membership is limited to persons who are serving in an administrative capacity within a physician group practice, with the exception of honorary, life and affiliated members. Affiliate members are individuals who supply products or services to IMGMA members.

WHY JOIN IMGMA?

- 1** *IMGMA enhances your professional growth, development and viability as a medical group manager.*
- 2** *IMGMA offers a variety of targeted educational opportunities.*
- 3** *IMGMA provides opportunities for members to share and disseminate information of mutual interest.*
- 4** *IMGMA maintains an active liaison with other key public and private organizations that affect the management, funding and delivery of quality physician care.*
- 5** *IMGMA dues are only \$75 per year.*



IOWA MEDICAL GROUP MANAGEMENT ASSOCIATION
1001 Grand Avenue, West Des Moines, IA 50265

Please send me an application for membership!

Name _____ Position _____

Organization _____

Address _____

City/State/Zip _____

Telephone Number _____ Number of Physicians _____

King Will and the Foul Humours: a fable for reform

Ladies and gentlemen, over the course of the last two years, we've been asked to believe several fairy tales in the name of health system reform. So today, I'd ask your indulgence as I tell one last fairy tale.

I'd like to tell you the story of King Will and the Foul Humours.

Once upon a time there were a King and Queen who lived in a big, white castle, surrounded by a big, black fence, that was regularly patrolled by knights wearing dark visors.

Before King Will had become King, he lived in the forest, where he took from the rich and gave to the poor. This made him quite popular—especially with the poor—but he mistook his popularity for wisdom, and no sooner had he moved into the white castle than he began searching throughout the Kingdom for problems to solve.

He said to the Queen "Queen (he always addressed her in this manner) do you perceive any problems that criest out for solutions?"

She replied: "Are you kidding? The knighthood could use a little more diversity. The plague is making a comeback. And every time you take your exercise, you can't stay away from the butcher shop."

Now the king ignored this last comment, but the problem of the plague seized his mind.

He knew many of his subjects were unable to see the Wizards—Doctors of Physic who ministered to the ill. And he knew the tithe for having their humours checked was rising faster than the Consumer Price Index.

But the King knew the magic of the Wizards was unsurpassed. Citizens from neighboring kingdoms would travel many leagues just to see them. The vast majority of his subjects were contented with their care and could see a Wizard almost whenever they wanted to.

The King mulled over his dilemma—he was famous for mulling and wonking—and finally, he said to the Queen: "It is up to us to give the people the health care they deserve."

Now a strange thing happened. The Queen might well have turned to the Wizards, who themselves had been discussing this problem and recommended remedies for many years. But instead, she summoned a noted sorcerer from a far away land, Ira of the Unruly Hair. And Ira gathered a legion of fellow sorcerers,

and convened them in a secret Star Chamber, a place so dank and dark no light could enter or escape.

They labored while the Spring blossoms scented the trees and the sun ripened the fruit on those trees. They labored while the leaves on those trees began to fall to the

**She
summoned
a noted
sorcerer, Ira
of the
Unruly Hair.**

earth. Then one day the Queen sent a crier throughout the Kingdom to announce that Ira of the Unruly Hair had indeed produced a mighty plan and it would be wondrous to behold.

Then they gathered every beast of burden in the Kingdom, all the oxen and horses and mules, and they hitched them to the machine on which they had placed the great plan—for the plan was not only great in inspiration but great in size—



ROBERT MCAFEE, MD
AMA president

Dr. McAfee, a surgeon practicing in Maine, gave this farewell speech at the AMA Interim Meeting in Hawaii.

Guest Editorial

continued

and they hauled it to the big, white castle and presented it to King Will.

King Will, chewing on the drumstick of a great wonk, placed his seal upon the plan.

Now on a hill looking down on the white castle was a Great Hallowed Hall with a round dome. In that Hall were knights of renown from every other castle in the Kingdom.

They were divided roughly into two camps. The shields of one camp bore the sign of the donkey; the shields of the other the sign of the elephant.

It was these knights' job to decide the laws of the land, but in truth, most of their days were spent in their favorite sport, jousting. The leader of the donkeys, Sir George of the Land of Lobster, was one of the most feared jousters. He said: "Bring us the plan of King Will, so we can make it the law of the land."

And the leader of the elephants, Sir Bobdole of the Land of Corn, famous for his skill with the lance, spoke: "This plan has more fat than a roasted boar," said Sir Bobdole.

The donkeys and the elephants had opposing views on the health care of the people. The donkeys believed the King and the knights should design the system, and decide what kind of training should be given to the Wizards and which Wizards the people could see. The donkeys believed if the subjects would pay their tithe to them—they could fix the system.

But the elephants said the people were tithed too much and the money was wasted on things like midnight falconry. And they said the King and the Great Hall should stay out of it. And they accused the donkeys of being beholden to a knight of yore, Sir Franklin of the New Deal.

So the knights of the donkeys and the knights of the elephants devised their own plans: Sir George of the Land of Lobster, Sir Chafce of Rhodes, Sir Stark of Fortney, Sir Teddy of

Camelot and others. But the champion of one plan, Sir Rosty of the Windy City, was injured when he was out delivering a gift to a subject and fell into a moat.

But these plans, too—five in all—were also placed on great machines and hauled out to be viewed by the people. And the knights returned to their jousting.

And now thick fog hid the sun, and thunder rent the air, and torrents of rain turned the land into mud, and the plans of King Will and all the plans of the Great Hall got bogged down.

All the while the Wizards offered advice and counsel on the health of the people. And the people heard them and gave the Wizards their confidence. But the King and Queen and many in the Great Hall gave the people only the cold shoulder and the deaf ear.

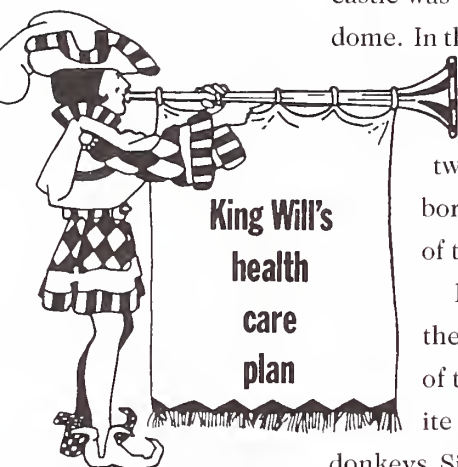
Now there arose in the land a new evil that further threatened the health care of the people.

One day, five great dragons from the Kingdom of Insurers appeared in the sky, and encamped in every corner of the Kingdom. And on their wide wings were markings sinister and strange. One had what looked like the giant rock of Gibraltar. Another had what looked like a great umbrella of crimson. Still a third was marked with a small cartoon beagle.

People called them the Big Five. They breathed fire and made a bellowing that was terrible to hear and were in general unmannerly. They began making forays across the land, swooping down upon unsuspecting subjects, herding them into their own regions.

They swallowed up entire villages. They plucked up select Wizards, and demanded that they tend only the citizens they had corralled, and none other. The citizens raised up a cry because they could no longer see the Wizards who had so carefully watched over them.

But as the dragons's plunder continued, their appetites grew more ravenous. It was rumored



But the elephants said the people were tithed too much and the money was wasted on things like midnight falconry.

that some dragons even tried to eat some of the others. And clouds darkened the sky and a great indigestion struck the bowels of the people, and they were sore afraid.

Ladies and gentlemen, most fairy tales end with everyone living happily ever after. For that to happen here, you might expect a white knight to appear and slay the dragons and knock some sense into the King, the Queen and the knights of the Hall on the Hill.

But the ending to this story has yet to be written.

The great plans of the King and Queen and all the knights of the Hall got bogged down under their own weight.

As a result, many knights lost their shields and left the Great Hall forever—although most went on to join the Guild of Lobbyists. Some who remained were hoping to fix the Kingdom's health system by mixing up a special magic potion. Its main ingredient was Eye of Newt.

Most of the knights, however, just went back to their jousting.

As for King Will and his Queen, the whole experience was enough to make them wish they were back in the forest, in their house surrounded by rushing white water.

The King has taken to traveling to foreign lands but never misses a chance to remind the Queen that you just can't trust a sorcerer.

What remains are the Wizards and the people—the true heart and soul of any health care system.

The people will continue to receive the best care on Earth when they demand nothing less.

We Wizards must never forget that we can deliver that care only if we're united in our vision, our voice and our leadership.

And, I believe we can write a fairy tale ending if we never forget that the true power of our magic is not what's under our hats, but what's in our hearts. **IM**

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IMS Update

AT A GLANCE

IMS leadership has approved a blueprint for specialty society representation in the IMS House of Delegates. The blueprint and amended bylaws will be submitted to the IMS House April 29. If adopted, specialty societies who meet criteria will be eligible to participate in the 1996 House of Delegates.

The IMS Judicial Council wants to hear the views of all IMS members regarding the format of the IMS House of Delegates meeting. Watch for a member survey in the April Iowa Medicine.

The American Hospital Association recently declared a "crisis of confidence" in the Joint Commission on Accreditation of Health Care Organizations, which accredits most of the nation's hospitals. More than 10 JCAHO chapters are considering alternatives; the AHA's president said the defection could lead to JCAHO's collapse.

Calling all IMS delegates

IMS delegates from across Iowa are urged to represent their counties at the 1995 IMS House of Delegates and Scientific Session April 28-30 at the Marriott Hotel, Des Moines.

The Scientific Session begins with a full day of programs on Friday, April 28 and concludes with a panel discussion of domestic violence on Sunday morning. (A program with registration information is enclosed with this *Iowa Medicine*.)

Election of officers will be held Sunday morning, April 30. Offices to be filled include: president-elect, vice president, trustee, House of Delegates speaker and vice speaker, two AMA delegates and two AMA alternate delegates.

IMS delegates should watch their mail for more information about the meeting, resolutions submitted, the slate of officer candidates and delegate handbooks.

FOCUS ON IMS ALLIANCE

Do you know violence when you see it? Or, are you like many of us who have witnessed so much violence in our lives we may not even recognize it?

IMS Alliance is asking everyone to "Turn Off the Violence" on Friday, March 31. We ask that you turn off violent television programs and violent music, boycott violent movies, not rent violent videos and turn off violence in all its ugly forms.

"Turn Off the Violence Day" will be the culmination of March, Medical Alliance Month. During March, 1,000 state and county medical alliances are celebrating by showcasing projects and programs they have developed to meet the unique health needs of their communities.

The IMS Alliance has over 1,100 members and is dedicated to the mission of improving public health, contributing to the AMA Education and Research Foundation and advocating sound health legislation on the state and national levels.

Contributed by Barbara Bell, president, IMSA

SPECIALTY SOCIETY UPDATE

The IMGMA will hold a strategic planning session March 3-4 to examine the future of the group and how best to meet members' needs.

Jerry Lewis, MD, legislative chair for the Iowa Psychiatric Society, also chairs the Mental Health Advocacy Coalition of all major mental health interests in Iowa. The Coalition has adopted model legislation to establish parity for mental health services under health insurance.

The American College of Cardiology, Iowa Chapter, will hold a reception March 20 in New Orleans in conjunction with the ACOC annual meeting.

Roy Overton, II, MD, president of the American Medical Directors Association, Iowa Chapter, has been appointed by Governor Branstad as a delegate to the White House Conference on Aging May 1-5. The AMDA spring meeting is April 20 at the Crystal Tree Inn, Des Moines.

New officers of the Iowa Oncology Society are: president — George Kovach, MD, Davenport; vice president — Roger Gingrich, MD, Iowa City; secretary/treasurer — Larry Otteman, MD, Ames. The next board meeting will be April 26 in Iowa City.

The Iowa Society for Rehabilitation Medicine spring meeting will be Friday, April 7 at IMS headquarters in West Des Moines.

The Iowa Association of County Medical Examiners board of directors will meet February 17 at IMS headquarters in West Des Moines to plan for the October annual meeting.

The Iowa Society of Anesthesiology will hold its annual meeting Saturday, April 1 at the Des Moines Convention Center.

Doctors' Day is March 30

In 1990, President George Bush signed a resolution designating March 30 as National Doctors' Day. The IMS Alliance salutes the Iowa physicians who serve our communities every day of the year.

Futures

Physician-patient relationship at risk

The ideal physician-patient relationship is being threatened by a number of factors, including the growth in managed care plans, according to several articles in a recent issue of *JAMA*.

The ideal physician-patient relationship is summarized by the six C's — choice, competence, communication, compassion, continuity and (no) conflict of interest.

The authors of the *JAMA* articles believe managed care plans have some benefits but could undermine this relationship. The authors say these elements are in jeopardy due to competition among managed care plans to cut costs and increase productivity.

The AMA's Council on Ethical and Judicial Affairs is concerned that financial incentives offered to physicians by managed care plans to lower costs could compromise what is best for patients and constitute a conflict of interest for physicians.

Federal antitrust judgment surprising

A federal jury assessed nearly \$50 million in antitrust damages against the 430-physician Marshfield Clinic located in central Wisconsin. Marshfield will appeal the verdict, a process which could take up to a year.

According to an article in *Modern Healthcare*, the verdict "increases the legal vulnerability of providers trying to gobble up market share in the name of building regional integrated delivery systems."

The plaintiff in the case is Blue Cross and Blue Shield of Wisconsin, which charged Marshfield with eight violations of various state and federal laws. The court is still considering the Blues' other request that Marshfield be required to sell its HMO and enough physician practices to end its "monopoly power".

In Springfield, Mo., a hospital has agreed to limit physician practice acquisitions in order to resolve the state's antitrust concerns.

AMA CALLS FOR MEDICARE REFORM

The American Medical Association is calling on Congress and President Clinton to sit down with physician leaders and work on the reform of Medicare, based on six principles that would increase cost consciousness by patients and more equitably distribute the burden of financing between generations.

AMA says the "annual cycle of cuts in benefits and reimbursement has exacerbated the problem of Medicare spending growth". The AMA framework for Medicare reform was announced by Lonnie Bristow, MD, the AMA's president-elect, in a nationally-broadcast address.

"There won't be any Medicare for the next generation unless we make serious changes now," Dr. Bristow commented.

The AMA's proposed Medicare treatment plan is built on the following six principles:

- Medical savings accounts and other instruments of personal monetary decision-making.
- More equitable financing so hard pressed young people aren't saddled with bills for affluent elderly.
- Price competition — relaxing controls.
- Simplification — tearing down the regulatory maze.
- Physicians join in a campaign to curtail unwanted and inappropriate care, with revision of liability laws.
- An unrelenting campaign to reduce fraud and abuse.

Is Congress serious about cuts?

In case you may be wondering whether members of Congress are serious about cutting the budget and streamlining government, the *Kiplinger Washington Newsletter* says they are. Apparently, members know the voters expect real cuts, not merely decreases in the rate of spending as in the past.

However, many experts are predicting cuts won't be as deep as promised and that cuts won't come easily because virtually every program has avid supporters. However, nothing is off-limits except Social Security.

continued

AT A GLANCE

Many people in a large Consumer Reports survey said they are highly satisfied with their physicians but have "a bone to pick" about physicians' communications skills. Among the findings reported in the February issue, 75% of respondents were very satisfied with their doctor; but 50% complained about at least one aspect of their care, particularly communication problems.

According to the Wall Street Journal, HMOs will continue to show strong profits. United Healthcare Corp. is expected to post a 40% rise; earnings for Humana rose 55% during the fourth quarter.

Futures

continued

Pundits are expecting a big fuss over Medicare, which will go into the hole in 1996 and be wiped out by 2002 unless something is done. Though many predict some action this year or next, it is believed Congress will delay clashing with senior citizens as long as possible over proposals such as raising Medicare premiums for wealthy elderly.

Meanwhile, President Clinton has vowed to shield Medicare and several other programs from cuts. These programs amount to roughly half of the federal budget.

Business is booming for lawyers who specialize in health care issues.

WORTH REPEATING

"Reforming health care without talking to doctors is like reforming courts without talking to judges. Doctors are willing to share the sacrifice — so long as we aren't the sacrifice."

AMA President-elect Lonnie Bristow, MD, during a National Public Radio broadcast.

AMA policy and Republican contract

The IMS has available an analysis prepared by the AMA of the Republican Contract with America and applicable AMA policy. The analysis has been delivered to Speaker Newt Gingrich, along with a cover letter arguing for inclusion of liability reforms and Medical Savings Accounts in "Contract" legislation.

Congressional Democrats are warning states that the Contract with America could cost them hundreds of billions of dollars.

For a copy of the AMA analysis, call Chris Clark at the IMS, 800/747-3070 or 515/223-1401.

Legal business is booming

According to a recent article in the *New York Times*, business is booming for lawyers who specialize in health care issues. As doctors and other providers scramble to cope with "the brave new world of joint ventures and managed care, the new business arrangements and transactions all require lawyers", said the *Times*. **IM**

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Legislative Affairs

Update on legislative issues

Following is an update on selected issues in the Iowa Legislature of interest to the IMS. As of press time, the following bills had been introduced:

Individual health insurance reform

This bill provides protection for individual health insurance policy holders similar to those in effect for small group insurance.

Rate restrictions

Restrictions include limiting rate variations for blocks of business and prohibiting use of rating characteristics other than age, geographic area and family composition without approval of the insurance commissioner.

Disclosure

Carriers are also required to make disclosures to prospective customers related to preexisting conditions and the extent to which rates are based on individual rating.

Renewal

Insurers are required to renew policies unless premiums have not been paid, the customer has committed fraud, the individual becomes eligible for Medicare, the carrier decides not to do business in Iowa any longer

or the commissioner finds continuation of coverage would not be in the best interests of other policyholders.

Continuation of coverage

Carriers who issue individual health benefit plans must make available a basic or standard plan to individuals who apply and agree to meet the provisions of the plan, if the individual applies within 30 days of discontinuation of another policy.

Preexisting conditions

The basic or standard benefit plan shall have no restrictions on preexisting conditions greater than 12 months.

Standards for plans

The commissioner will set standards for the basic and standard plans.

STATEWIDE TRAUMA PLAN — SSB 50

This proposal from the Iowa Department of Public Health is based on recommendations of the Iowa Trauma System Development Project Planning Consortium. Ten physicians served on the consortium. The legislation establishes a trauma designation system for hospitals to help ensure a coordinated system of trauma care. The bill does not include restrictions on the type of care that may be provided by any hospital.

MEDICAL SAVINGS ACCOUNTS — HSB 51

This bill allows full deduction of the cost of health insurance premiums for individuals, allows a deduction of \$1800 for individuals and \$4200 for families for contributions to a "family health account". Family health accounts may be used as a repository for government subsidies for health insurance, employer contributions for health care, to receive money from the individual for health insurance, for purchase of a health benefit plan, to pay deductibles or copayments, to pay health care providers and to pay for long-term care services or insurance.

AT A GLANCE

There is still time to register for the Iowa Medical Society's Medicine Day to be held Wednesday, March 22. Iowa physicians and their spouses will eat lunch at the IMS, then travel to the Statehouse to talk to legislators, attend committee meetings and hear debate. To register, call Paul Bishop or Lyn Durante at the IMS, 515/223-1401 or 800/747-3070.

The IMS CHMIS Committee is recommending adoption by the IMS House of Delegates of a "statement of principles" to guide IMS participation in development of the CHMIS system. See this month's Medical Economics Section for more details.

CONTACTING YOUR LEGISLATORS

Telephone numbers during the session:

Senators 515/281-3371
Representatives 515/281-3221
Governor 515/281-5211

Write to them at:

STATEHOUSE
Des Moines, Iowa 50319

You may contact your legislators at home when the Iowa Legislature is not in session. If you don't know your legislator's home address and phone number, call Lyn Durante of the IMS staff, 515/223-1401 or 800/747-3070.

continued

Legislative Affairs

continued

EMERGENCY MEDICAL SERVICES — SSB 55

The bill consolidates regulation of prehospital emergency medical services under the Department of Public Health and would require all EMS services to be licensed by the DPH.

Several liability bills have been introduced, including HF 27, HF 31 and HSB 17. These proposals including a \$250,000 limit on noneconomic damages and various limits on the statute of limitations for minors.

In addition, several key public health bills have been introduced.

MOTORCYCLE HELMET LAW — SSB 54

Requires motorcycle operators and passengers to wear approved protective headgear while riding a motorcycle. Operators would be fined \$50, passengers \$25 for noncompliance.

TOBACCO FREE COALITION

The IMS is working with the Tobacco Free Coalition and the Iowa Department of Public Health on improving enforcement of the clean indoor air act and laws related to youth access to tobacco.

AMA legislative priorities

Medical savings accounts — AMA supports IRA-type medical expense accounts and broader, more flexible proposals.

Regulatory relief/CLIA — AMA is working with the Clinton Administration and Republicans in Congress to obtain CLIA repeal or reform and relief from OSHA blood borne disease requirements and other burdensome regulation.

Professional liability reform — The AMA is working with a coalition to ensure that reforms including a cap on noneconomic damages are included in the Common Sense Legal Reform Act of 1995.

Medicare reform — AMA opposes quick fix reimbursement reductions in favor of reform which gives the program long-term stability. (See this month's Futures section.)

Antitrust relief — Previous proposals died with health care reform bills. The AMA will work to provide relief for physicians trying to compete in the new marketplace. **IM**

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Medical Economics

IMS policy on CHMIS recommended

The Iowa Medical Society's CHMIS committee is recommending that the House of Delegates adopt an official statement of IMS operating principles. These principles will guide IMS participation in development and implementation of the Iowa Community Health Management Information System. The proposed policy statement will be submitted for approval to the IMS House of Delegates next month. The policy statement addresses key issues of concern to physicians, such as confidentiality and cost implications.

Iowa's CHMIS, signed into law by Governor Branstad last April, 1994, is scheduled to be implemented in three phases.

Phase 1, electronic claims submission, will go into effect July 1, 1996. Phase 2 will involve expansion of data collected from physicians and will be implemented July 1, 1999. Phase 3 may involve patient-specific electronic medical records. Phases 2 and 3 cannot be implemented without further action by the Iowa Legislature.

Iowa physicians are represented on the CHMIS Governing Board and on the Governing Board's five advisory committees. Physicians on the Governing Board and advisory are also ex-officio members of the Iowa Medical Society's CHMIS Committee.

At a meeting January 24, the IMS CHMIS

Committee received an overview of CHMIS activities from Dr. Dale Andringa, a member of the CHMIS Governing Board. The committee also heard about activities of the five Governing Board advisory committees.

The IMS committee held a lengthy discussion during which concerns about various aspects of CHMIS were expressed by committee members. It was emphasized that CHMIS is a concept at this time; final decisions have yet to be made on many issues of concern to physicians. Physician input into the CHMIS is crucial, said Dr. Terrence Briggs, chair of the IMS CHMIS Committee.

History of CHMIS development

The Iowa Medical Society has been involved in the CHMIS process since the system was first proposed several years ago. At that time, CHMIS was touted as the information component of health system reform in Iowa. The idea of a CHMIS for Iowa gained solid support very early in the process due to increased demands from business and consumer groups for health care accountability.

"The Iowa Medical Society asked for a seat at the table and was able to vastly improve the legislation which was eventually introduced in the Iowa Legislature," comments Dr. Briggs. "The very first proposals involved simultaneous implementation of electronic

continued

AT A GLANCE

On April 1, 1995, Medicare Part B will change to a computer processing system called MCS. This change does not change Medicare rules and you can continue to submit your EMC transmissions as usual. However, there will be a completely different provider remittance notice. Watch your Medicare Infos for additional details.

The ABI Workers Compensation Seminar will be March 14, 1995 at the Hotel Fort Des Moines. For registration information, call Barbara Heck of the IMS staff, 515/223-1401 or 800/747-3070.

USA Today reports that there is a trend among hospitals to lay off RNs and have less trained workers do patient care once reserved for nurses.

IOWA MEDICAL SOCIETY HOLDS CHMIS INFORMATIONAL MEETINGS

IMS staff have been presenting a CHMIS overview to many county medical societies across Iowa. As part of the Society's continuing effort to educate member physicians about CHMIS, the following additional CHMIS informational meetings have been scheduled.

**March 7, 5:30 p.m., Outing Club
Scott County Medical Society**

**April 7, 9:00 a.m., Marriott Hotel
Des Moines (Iowa Psychiatric Soc.)**

**April 26, Noon, University of Iowa
Iowa Oncology Society**

**March 8, 7:30 a.m., Genesis East
Davenport**

**April 10, 6:00 p.m., Hospital Bd. Room
Storm Lake**

**May 6, 9:00 a.m., University Park
Des Moines (Ia. Urological Soc.)**

**March 20, 6:00 p.m., Hospital Bd. Room
Mahaska County Medical Society**

**April 22, 9:00 a.m., University of Iowa
Iowa Clinical Society of Internal Med.**

Medical Economics

continued

claims processing, a central data repository and electronic patient records."

Due to IMS involvement, Dr. Briggs adds, the proposal which was finally introduced in the legislature broke these components into three phases — with phases 2 and 3 requiring additional legislative action before implementation. IMS representatives were able to include other physician-friendly provisions into the legislation.

At the January meeting, the IMS CHMIS Committee also reinforced the need for a timely communications link between IMS member physicians and the physicians serving on the CHMIS Governing Board and advisory subcommittees.

Benefits of CHMIS Phase 1

- According to a national study by WEDI, physicians will save \$1.07 per claim through electronic submission.
- There will be less administrative hassle since every insurance company will have to accept one standard claims format.
- There will be a faster turnaround time for

payment of claims.

•Physicians will have access to useful data on practice patterns.

•The CHMIS will replace the current Health Data Commission and data collection efforts will be made easier for physician offices.

Iowa's Medicaid plan awash in lawsuits

According to a story in the *Des Moines Register*, two more health care management companies are suing the state of Iowa to prevent the Department of Human Services from awarding a \$100 million contract for psychiatric care of Iowa's Medicaid patients.

The companies were unsuccessful bidders for the contract. They are asking Polk County District Court to end negotiations between Iowa DHS officials and Medco, which was awarded the contract in December. The companies are also asking that the entire bidding process be reopened.

As of press time, Medco was scheduled to take over management of psychiatric services for Iowa's 190,000 Medicaid patients March 1. **IM**

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"You Asked for It! We Have It!"

Specialty Coding Extravaganza

Date: April 18, 19, 20, 1995
Time: 8:30 a.m. to 4:30 p.m.
Where: Best Western Des Moines International,
1810 Army Post Road, Terrace 4

Nancy Maguire, RN, CPC, CPC-H, CRT, executive director of education and the dean of AAPC University, will be in Des Moines for a three-day specialty coding workshop. Ms. Maguire will field questions on all aspects of CPT, ICD-9-CM, HCPCS coding and also supply helpful tips in internal office control.

Tuesday, April 18

8:30 a.m. to 12:00 noon—**PEDIATRICS**

"Get practical advice to avoid reimbursement pitfalls."

1:00 p.m. to 4:30 p.m.—**SURGICAL CODING**

"Bill the right surgical codes every time and avoid duplication and unbundling edits."

Wednesday, April 19

8:30 a.m. to 4:30 p.m.—**PRIMARY CARE**

"Avoid mistakes in E & M codes, modifiers and effective internal office controls."

Thursday, April 20

8:30 a.m. to 4:30 p.m.—**ORTHOPEDIC SURGERY, NEUROSURGERY AND ENT**

"Get the best of tricky surgical codes and surgery modifiers with discussion on actual operative notes."

COST:

1 full day: \$175 for IMS member or staff, \$280 for non-member or staff

1/2 day: \$110 for IMS member or staff, \$175 for non member or staff

1 1/2 day: \$260 for IMS member or staff, \$430 non-member or staff

2 full days: \$320 for IMS member or staff, \$530 for non-member or staff

3 days: Call IMS for details.

Continental breakfast and
lunches served for full days.
Refreshments during breaks.

Health Insurance Overview

Tues, 4/11	IMS Headquarters, Taylor Room, West Des Moines
Wed, 4/12	St. Luke's Regional Medical Center, Room 2, Sioux City
Thurs, 4/13	North Iowa Mercy Health Ctr, West Campus, Mason City
Tues, 4/25	Bettendorf Medical Plaza Conference Center, Davenport
Wed, 4/26	Jennie Edmundson Memorial Hospital, Auditorium, Council Bluffs

This seminar is an overview of the basics of health insurance including insurance principles, contract and benefit highlights, insurance claim filing systems, tips for trouble-shooting claim payment problems and post-payment monitoring systems. It includes information on Medicare, Medicaid and private insurance. Seminar time is 9:00 a.m. to 4:00 p.m. The cost, which includes lunch, is \$150.00 for an IMS member or staff and \$240.00 for non-member or staff.

★ This program is part of the IMS Medical Business Specialist (MBS) Certificate Program.

REGISTRATION ON REVERSE SIDE

**Please copy this form and complete a separate
registration form and separate payment for each program**

Registration Form

SPECIALTY CODING SEMINAR

Name(s): _____

Clinic/Practice Name: _____

Address: _____

Phone: _____ Fax: _____

Amount Enclosed: _____ Date: _____

Please make checks payable to IMS SERVICES. Mail check and registration form to:

IMS SERVICES

ATTN: Sherry Johnson

1001 Grand Avenue

West Des Moines, IA 50265-3599

Registration Form

HEALTH INSURANCE OVERVIEW

Name(s): _____

Clinic/Practice Name: _____

Address: _____

Phone: _____ Fax: _____

Amount Enclosed: _____ Date: _____

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IMS SERVICES

ATTN: Sherry Johnson

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Practice Management

You asked for it, we have it!

Do you want answers to tough questions on all aspects of CPT, ICD-9 and HCPCS coding?

The Iowa Medical Society and IMS Services will sponsor a coding extravaganza Tuesday, Wednesday and Thursday, April 18, 19 and 20 at the Best Western Des Moines International.

Nationally known coding expert Nancy Maguire will teach the seminars. Maguire is executive director of education and the dean of the American Academy of Procedural Coders.

The first session on Tuesday, April 18 will cover **Pediatric Coding** from 8:30 a.m. until noon. The afternoon session from 1:00 p.m. to 4:30 p.m. will cover **Surgical Coding**.

On Wednesday, April 19, the session will be devoted to **Primary Care Coding** and avoiding mistakes in E & M Codes and modifiers.

Orthopedic Surgery, Neurosurgery and ENT Coding will be in the spotlight on Thursday, April 20. This seminar will cover how to get the best of tricky surgical codes.

All sessions will be held at the Best Western Des Moines International from 8:30 a.m. until 4:30 p.m.

The cost for a full-day seminar (IMS member or staff) is \$175; \$280 for a nonmember. This includes lunch. The cost for a half-day seminar is \$110 for an IMS member; \$175 for a nonmember.

The cost of attending two full days is \$320 for an IMS member or staff; \$530 for a nonmember. The cost for attending one and a half days is \$260 for an IMS member or staff; \$430 for nonmembers.

For more information on these specialty coding seminars, call Mary Reinsmoen at IMS Services, 515/223-2816.

Documentation review service

In late summer or early fall of this year, the Health Care Financing Administration plans to start auditing physician offices for medical record documentation that correctly supports charge and diagnosis codes.

If you feel you need assistance with the new documentation guidelines, staff at IMS Services may be able to help.

If you would like an on-site review of your E & M Coding documentation — including a review of your charts — IMS staff is available to assist you.

For further information on arranging an on-site visit and on fees, call Mary Reinsmoen at the IMS, 515/223-2816 or 800/728-5398.

Are you communicating effectively?

In a recent survey done by *Consumer Reports*, 75% of respondents said they are satisfied or very satisfied with their physician. Overall, 50% of respondents complained about one aspect of their care — physician communication skills. **IM**

AT A GLANCE

Usage reports indicate IMS member physicians who are using the Airborne Express program have experienced an overall savings of 43.7%. For more information, call Sandy Nelson at IMS Services, 515/223-2816 or 800/728-5398.

Watch your mail for information on a new individual travel club program which will be available soon through IMS Services.

Reminder: bloodborne pathogens training is required annually for all employees (and initially for new employees).

PRACTICE MANAGEMENT WORKSHOPS FOR YOU

HEALTH INSURANCE OVERVIEW

Tues., April 11	IMS headquarters
Wed., April 12	Sioux City
Thurs., April 13	Mason City
Tues, April 25	Davenport
Wed., April 26	Council Bluffs

CODING SEMINARS

APRIL 18, 19, 20

(All sessions at Best Western, Des Moines International)

Pediatric, Surgical Coding	April 18
Primary Care Coding	April 19
Orthopedic Surgery/Neurosurgery and ENT Coding	April 20

Taught by Nancy Maguire, director of education and dean of the American Academy of Procedural Coders. (See story above for additional details.)

For more information or to register for any IMS practice management workshop, call Mary Reinsmoen or Sherry Johnson at IMS Services, 515/223-2816 or 800/728-5398.

Practice Management

continued

MIDWEST MEDICAL INSURANCE COMPANY FOCUS ON RISK MANAGEMENT

Failure to diagnose colon cancer

Failure to diagnose colon cancer is one of the most frequent and costly malpractice claims made against physicians. Colorectal cancer is the second leading cause of cancer deaths in the U.S. Nearly 50% of patients with colon cancer die from the disease.

A study by the Physician Insurers Association of America of 151 closed malpractice claims involving delay in diagnosis of colon cancer showed several factors contribute to the delay or missed diagnosis:

- Failure to perform an endoscopic exam. In 73% of cases, the cancer could have been diagnosed by sigmoidoscopy.
- Failure to perform a barium enema.
- Failure to adequately respond to symp-

toms of rectal bleeding, abdominal pain and cramping, changes in bowel habits, anemia and weight loss.

- Failure to elicit a patient and family history.

- Failure to check for occult blood.

- Failure to further investigate guaiac positive stools when hemorrhoids are present.

- Lack of follow-up care with no system to find out whether patients returned as advised.

- Lack of communication between treating physicians regarding who is responsible for follow-up.

For further information, contact Lori Atkinson, MMIC risk management coordinator, MMIC West Des Moines office, PO Box 65790, West Des Moines, 50265, 800/798-9870 or 515/223-1482.



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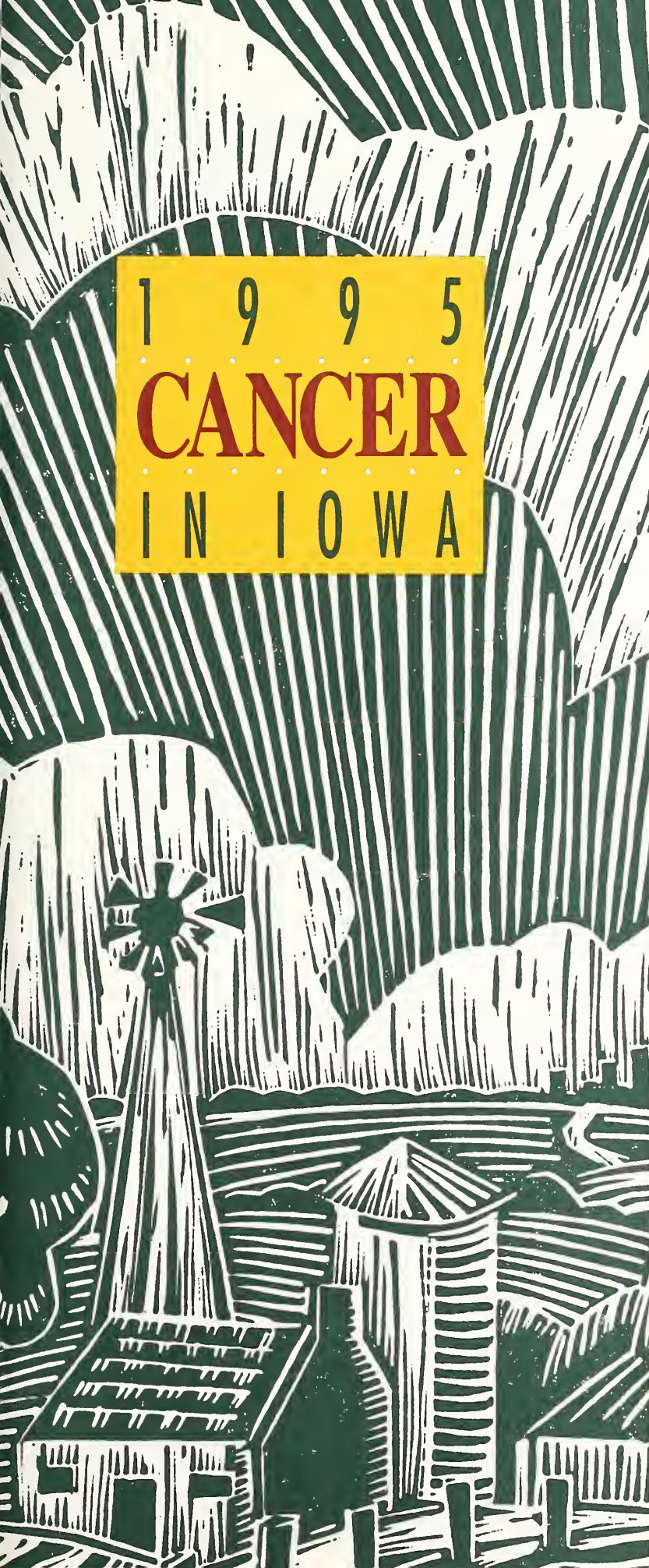
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1 9 9 5
CANCER
I N I O W A

FACTS ABOUT **CANCER** IN IOWA

Prostate cancer will comprise 30 percent of all new cancers in males

Rates of new cancers have increased 41% among males and 23% among females when comparing 1973 to 1992

Every year five out of six cancers occur in Iowans 55 years of age and older

Visit your physician regularly

Early detection is important

Newly diagnosed breast cancer will comprise 30 percent of all new cancers in females

Teach the practice of self-examination

In 1995, an estimated 6,545 Iowans will die from cancer, 14 times the number caused by auto fatalities. Cancer is second only to heart disease as a cause of death. These projections are based upon data from the State Health Registry of Iowa. The registry has been recording the occurrence of cancer in Iowa since 1973.

As one of ten registries in the country funded by the National Cancer Institute (NCI), Iowa represents the rural and Midwestern populations and provides data found in many NCI publications.

Produced by

STATE HEALTH REGISTRY OF IOWA

The University of Iowa, 100 Westlawn S.
Iowa City, IA 52242-1100 (319) 335-8609

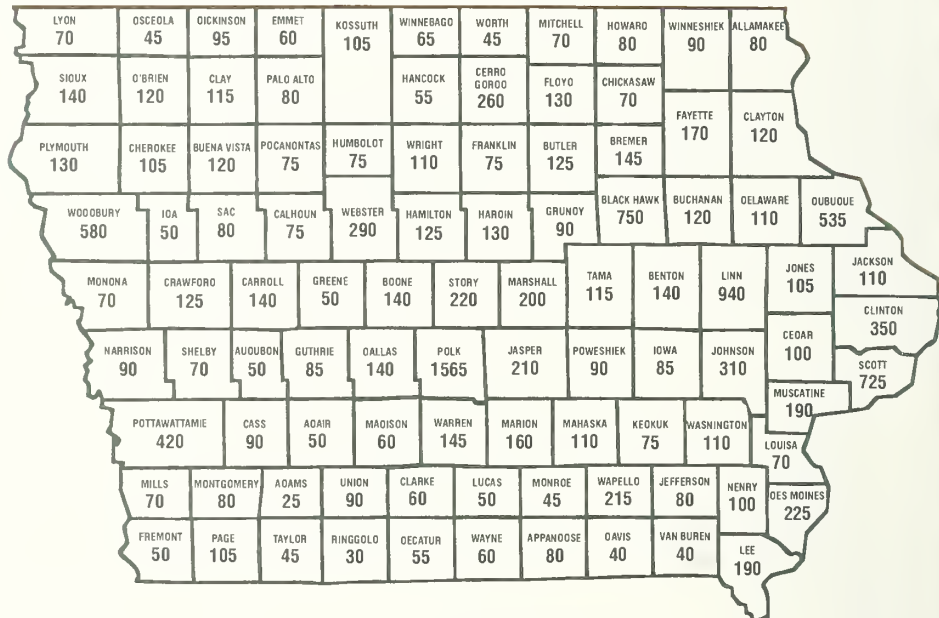
The State Health Registry of Iowa is located at The University of Iowa in the College of Medicine's Department of Preventive Medicine and Environmental Health. The staff includes more than 50 people. Half of them, situated throughout the state, regularly visit hospitals, clinics, and medical laboratories in Iowa and neighboring states. In 1995, data will be collected on 15,400 new cancers among Iowa residents. A follow-up program tracks more than 97 percent of the 270,000 Iowans diagnosed with cancer since 1973. This program provides regular updates to keep the data current and useful.

This excerpt provides information from the State Health Registry's annual publication *1995 Cancer in Iowa*.

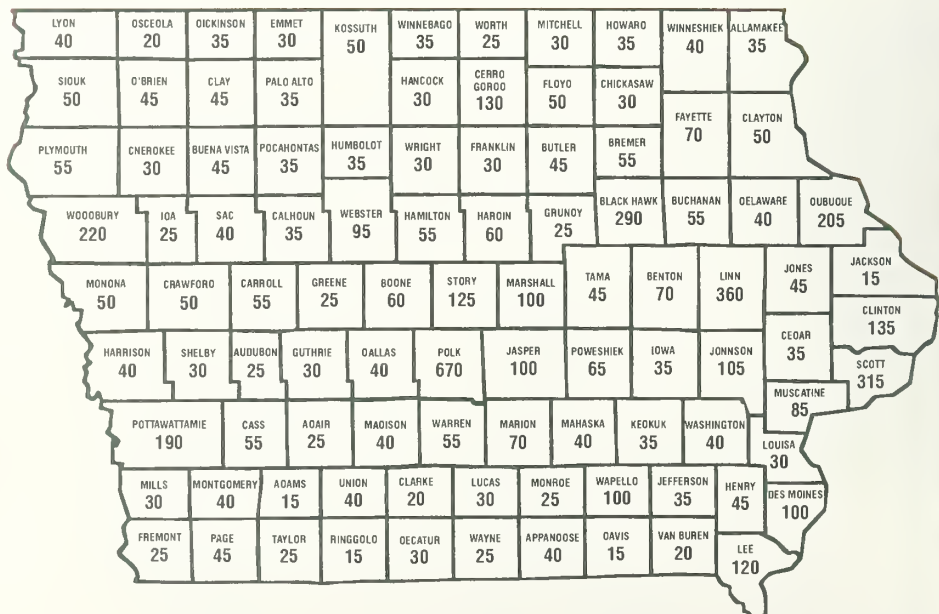
ESTIMATED NUMBER OF NEW CANCERS IN IOWA FOR 1995

CANCER PROJECTIONS FOR 1995

Cancer affects Iowans of all ages and in every county. In 1995, cancer will strike five out of every 1,000 and bring death to two of them.



ESTIMATED NUMBER OF CANCER DEATHS IN IOWA FOR 1995



Breast cancer is the most common female cancer and, along with colon, rectum, and lung cancers, will account for more than half of all new cancers. Lung cancer is the most common cause of cancer death in females followed closely by breast cancer.

TOP 10 TYPES OF CANCER IN IOWA ESTIMATED FOR 1995

New Cancer in Females		
TYPE	# OF CASES	% OF TOTAL
BREAST	2225	30.5
COLON & RECTUM	1125	15.4
LUNG	790	10.8
UTERUS	440	6.0
NON-HODGKIN'S LYMPH.	315	4.3
OVARY	290	4.0
LEUKEMIA	210	2.9
SKIN MELANOMA	190	2.6
PANCREAS	185	2.5
KIDNEY & RENAL PELVIS	160	2.2
ALL OTHERS	1370	18.8
TOTAL	7300	

New Cancer in Males		
TYPE	# OF CASES	% OF TOTAL
LUNG	600	19.4
BREAST	565	18.3
COLON & RECTUM	425	13.7
OVARY	175	5.7
PANCREAS	160	5.2
NON-HODGKIN'S LYMPH.	150	4.8
LEUKEMIA	120	3.9
UTERUS	95	3.0
BRAIN	75	2.5
MULTIPLE MYELOMA	75	2.4
ALL OTHERS	650	21.1
TOTAL	3090	

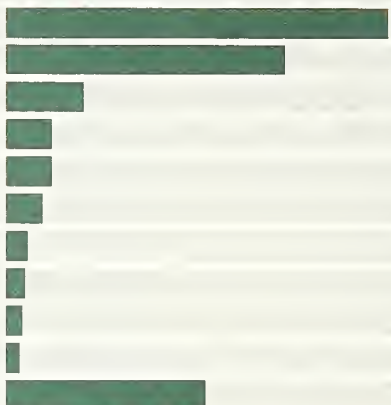
Prostate, lung, colon, and rectal cancers account for over 60 percent of all new cancers in males. Lung cancer causes almost one-third of all male cancer deaths.

New Cancer in Males		
TYPE	# OF CASES	% OF TOTAL
PROSTATE	2500	30.9
LUNG	1410	17.4
COLON & RECTUM	1040	12.8
NON-HODGKIN'S LYMPH.	310	3.8
LEUKEMIA	250	3.1
BLADDER	250	3.1
SKIN MELANOMA	210	2.6
KIDNEY & RENAL PELVIS	205	2.5
ORAL CAVITY	185	2.3
PANCREAS	170	2.1
ALL OTHERS	1570	19.4
TOTAL	8100	

New Cancer in Females		
TYPE	# OF CASES	% OF TOTAL
LUNG	1120	32.4
PROSTATE	455	13.2
COLON & RECTUM	395	11.4
PANCREAS	165	4.8
LEUKEMIA	150	4.4
NON-HODGKIN'S LYMPH.	150	4.3
BLADDER	100	2.9
ESOPHAGUS	95	2.8
BRAIN	95	2.7
STOMACH	80	2.3
ALL OTHERS	650	18.8
TOTAL	3455	

Cancer remains the second most common cause of death behind heart disease. The percentage difference between heart disease and cancer is narrowing.

TOP 10 CAUSES OF DEATH IN IOWA ESTIMATED FOR 1995

CAUSE		NO.	PERCENT
HEART DISEASE		8990	33.0
CANCER		6545	24.0
CEREBROVASCULAR DISEASE		1960	7.2
CHRONIC OBSTRUCTIVE & PULMONARY		1200	4.4
PNEUMONIA		1170	4.3
ACCIDENTS		1065	3.9
DIABETES		545	2.0
ARTERIOSCLEROSIS		380	1.4
OTHER ARTERIAL DISEASES		355	1.3
INFECTIONS		325	1.2
ALL OTHER CAUSES		4715	17.3

Cancer occurs in people of all ages, although more than 80 percent of all new cancers occur in those 55 years of age and older.

TOP 3 TYPES OF NEW CANCERS IN IOWA ESTIMATED FOR 1995: Females & Males by Age Group

			TYPE	# OF CASES
Ages			BREAST	690
			COLON & RECTUM	595
			LUNG	240
75+			PROSTATE	1100
			LUNG	460
			COLON & RECTUM	430
Ages			BREAST	965
			LUNG	470
			COLON & RECTUM	460
55-74			PROSTATE	1400
			LUNG	840
			COLON & RECTUM	530
Ages			BREAST	570
			UTERUS	100
			CERVIX	85
15-54			LUNG	110
			SKIN MELANOMA	85
			COLON & RECTUM	80
Ages			LEUKEMIA	10
			BRAIN	5
			BONES & JOINTS	5
Under			LEUKEMIA	15
			BRAIN	10
			NON-HODGKIN'S LYMPH.	5
15				

Fortunately for Iowans, the chances of being diagnosed with many types of cancer can be reduced through positive health practices such as smoking cessation and healthful dietary habits. Early detection through self-examination and regular health checkups can dramatically improve cancer treatment and survival. The 1990s have shown increasing numbers of non-invasive breast cancers, largely the result of early detection due to mammography screening. Preventive measures and early detection should continue to show positive changes in the cancer statistics reported by the registry.

Newsmakers

Domestic violence response

Dear Editor:

I want to thank you for all you did to make the January issue of the journal so informative. Your insight into the issue of domestic violence was obvious and the articles were effectively presented for this group of health care professionals. I've received great feedback.—*Kay Maher-Sharp, Family Violence Center, Des Moines.*

Achievements

Dr. Richard Williams, professor and head of the Department of Urology, UI College of Medicine, has been appointed to occupy the first Rubin H. Flocks Chair in Urology. The following physicians have been elected officers of the Polk County Medical Society: **Dr. Steven Phillips**, president-elect; **Dr. Michael Witte**, secretary-treasurer; **Dr. Steven Cahalan**, councilor and **Dr. Lynn Struck**, trustee. **Dr. Scott Thiel**, family practitioner at McFarland Clinic in Boone, won honorable mention at an Ames art show for his pastel print entitled "Uncle Clarence and Aunt Glates." **Dr. Tolbert Fellows**, UI professor of physiology, is president-elect of the Association of Neuroscience Departments and Programs. The organization works to advance education and research training in neuroscience. The 1995 medical staff officers of the Mercy Medical Center in Cedar Rapids are **Dr. Fred Pileher**, orthopaedic surgeon with Iowa Medical Clinic, president; **Dr. Darrell Dennis**, pulmonologist with Internists, P.C., vice president and **Dr. Alan Robb**, family practitioner, secretary-treasurer. **Dr. Mark Thompson**, UI fellow associate in pediatrics, received the Kinney Award for Young Pediatric Researchers for his presentation at the Midwest Society for Pediatrics Research annual meeting. **Dr. Richard Tyler**, UI professor of otolaryngology, re-

ceived a Special Recognition Award from the American Tinnitus Association for his commitment to tinnitus research and education. **Dr. Otnar Albrand** has relocated from Ogden to Dubuque where he will be practicing neurosurgery at Grandview Medical Center.

New members

Iowa City

Douglas Boatman, MD, diagnostic radiology
William Daniel, Jr., MD, diagnostic radiology
Alan Fedge, MD, diagnostic radiology
Ingrid Goldenstein, MD, pediatrics
Robert Hertig, Jr., MD, resident
Wayne Janda, MD, orthopedics
Denise Kolbert, MD, resident
Paul Skopce, MD, diagnostic radiology
Timothy Skopce, MD, diagnostic radiology
John Stamler, MD, ophthalmology
James Wiese, MD, diagnostic radiology

Kalona

Naney Nelson, MD, family practice

Keokuk

Robert Lorey, DO, obstetrics/gynecology

Mason City

Jonathan McLaughlin, MD, general surgery
Kevin Rier, MD, urology

Marshalltown

Michael Sickels, MD, internal medicine


Mediapolis

Russell Lyons, DO, internal medicine, family practice

Nevada

Perry Rathe, MD, family practice

Deceased member

Gary Castle, DO, 58, Coon Rapids, died December 25 

AT A GLANCE

The Allied Health Committee of the Iowa Board of Medical Examiners recently approved three Lake City Family physicians for the Iowa Volunteer Physician Program: Dr. Dale Christensen, Dr. Robert Ferguson and Dr. Ashton McCrary. Dr. Robert McCool, Clarion, has also been approved for the program.

Details on the 1995 IMS House of Delegates and Scientific Session can be found in the program in the center of this issue of Iowa Medicine.

Pitfalls OF *integration*

A decision to integrate should be made only after a thorough analysis of what the physician has to gain and the potential risks. The author analyzes several of the models for physician/hospital integration found in today's marketplace.

Though it is clear that physicians should be alert to the potential pitfalls associated with various health care integration models, this does not mean physicians should shy away from employing these new strategies to cope with today's shifting environment.

It does mean all factors must be weighed against the potential benefits of increased managed care contracts, reductions in practice overhead and better management.

This is a major business decision for physicians which must be made carefully.

Changing strategy for hospitals

The evolution towards vertical integration of the health care delivery system has resulted in development of a new strategy by hospitals and hospital systems — namely, purchase of predominantly primary care practices and employment of physicians as part of a single delivery system.

The primary result is that more private practice physicians become employees of hospitals or hospital systems. Many physicians are reluctant to sell their practices and become employees (or independent contractors) of the hospital system for several reasons:

concern about giving up control of the practice; concern about the hospital's ability to effectively manage the office; fear of termination if the hospital finds a physician who will work for less money; a change in attitude required to become an employee; lack of incentive to make the business grow; concern over being insured by the hospital's choice of malpractice carrier; reduced options if the hospital makes the wrong decision in terms of overall management or managed care contracting.

Thus, alternative structures have evolved which deliver physicians collectively into the managed care marketplace.

Models for integration

One option is an **Independent Practice Association** or a **Physician Organization** established to allow unrelated practices to organize into a single unit in order to obtain managed care contracts. These models do not include patient care except as it relates to incentive compensation paid to the IPA/PO for efficient utilization of inpatient care below a predetermined target. The IPA/PO is owned by physicians and

The IPA/PO model is not the most efficient to accommodate managed care patients.

ROBERT KRYPEL, JD
Mr. Krypel is a partner in the Chicago office of Healthcare Management Consultants, LP. He is a frequent contributor to Modern Healthcare, Medical Economics and other publications.



association with a hospital occurs only if a patient is admitted or needs outpatient services.

This model is not the most efficient to accommodate managed care patients because there is no uniform effort by the IPA/PO members to reduce costs. Clinical results may be uniform, but costs associated with the delivery of care can vary widely.

The results of this disparity and the need for capital have led to development of the **Physician Hospital Organization (PHO)**. It operates similarly to the IPA/PO except that a hospital or health system is one corporate member and the physicians (either as an IPA/PO or as individuals) constitute another member. This model allows physicians to reduce the capital risk associated with developing an IPA because the hospital shares start-up costs.

However, the PHO is also not in a position to control costs. Unless the PHO is taking full risk contracts (rare in today's market), it is assuming risk on only the professional component of the contract. Physicians are unable to share in profits generated by the hospital as the result of efficient care provided by physicians. Although a bonus may be paid to the PHO based on controlling lengths of stay below a predetermined amount, this would be available to the physicians without a hospital partner.

Abdicating responsibility

Finally, experience suggests that if physicians organize through a PHO, they eventually abdicate their responsibility in the contracting process to the hospital. The result is an increased risk by physicians

regarding effective control of patients. This increases the ability of the hospital to take control by redirecting patients to physicians employed by the hospital rather than members of the PHO.

Another model is the solo or small medical group merger into larger primary care practices, multi-specialty or single-specialty group practices. A large medical group can reduce costs and make the group more attractive to managed care organizations.

Apprehension about consensus building

However, there are significant obstacles. One is reluctance by physicians to underwrite the startup costs such as legal, accounting and consulting fees. There is also apprehension regarding creating a structure that requires consensus building among disparate members. These obstacles and the common requirement of physicians to execute a non-compete covenant often doom a possible merger.

Finally, even successful mergers cannot guarantee higher net incomes to members.

A recently developed model is the fully integrated delivery system, which employs primary care physicians. However, there are financial and legal risks.

**Even successful
mergers cannot
guarantee higher
net incomes
to the members.**

**The Office of
Inspector General
has suggested that
payment for good
will is inappropriate
and subject to
review.**

The legal risks include potential violations of Medicare fraud and abuse statutes, inurement issues, employment contract issues and corporate practice of medicine laws in various states. Although many physicians have sold their practices to hospitals in the past, there is a frequent and mistaken belief that fraud and abuse laws apply only to the purchaser. In fact, they apply to both seller and buyer and sanctions can be civil or criminal.

Payment for good will

Potential legal risks relate primarily to the purchase price allocated for good will. The Office of Inspector General has suggested that payment for good will is inappropriate and therefore subject to review. An alternative approach is to pay compensation to an employed physician which is greater than the market value of the practice.

Inurement relates to the inability of a tax-exempt organization such as a hospital to transfer tax-exempt status to others for private benefit. To prevent the institution from jeopardizing its tax-exempt status, the purchase price must reflect fair market value.

State statutes prohibiting corporate practice of medicine and enforcement of those provisions may be lax. Therefore, it is important for the physician to obtain counsel to prevent practicing medicine through an unlicensed business organization.

Restrictive covenants

The contract which outlines the terms of a physician's employment subsequent to the sale of a practice undoubtedly include a

restrictive covenant limiting the ability of the physician to practice within a defined geographical area for a specific period of time subsequent to termination of the contract by either party. The physician may be prevented from hiring any employees of the employer hospital for a period of one to two years after termination. Although such restrictions are necessary for the purchaser, they must be reviewed by the physician in order to determine under what circumstances the physician may want to terminate employment by the hospital.

Conditions under which the physician or the hospital may wish to terminate the relationship include:

- Cause — reasonably acceptable to both parties.
- Cost — the hospital can hire competent, skilled physicians for less money.
- Market shifts — the hospital loses a managed care contract serviced in part by the physician.
- Personalities — the hospital or the physician find they cannot work with the other.

If the physician's employment is terminated for any of these reasons, he or she would be forced to start a new practice under significantly limited conditions.

Evaluate your options thoroughly

The most important thing to remember is never make a major business decision without appropriate analysis of all your options. Today's rapidly changing environment demands nothing less than a thorough evaluation of the possible benefits versus the potential pitfalls. **IM**

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The Journal

of the Iowa Medical Society

Antibiotic resistance: an emergency we can't ignore

● STEPHEN RINDERNECHT, DO

In the near future, effects of antimicrobial resistance will be felt by physicians and patients alike. Drugs once used to treat infections are often becoming less effective as bacteria adapt to their changing environment. As a result, physicians are sometimes forced to prescribe stronger, more expensive and more toxic antibiotics.

This trend is contributing significantly to the cost of health care in terms of prolonged hospitalization, more expensive medications and increased morbidity and mortality in patients infected by multiple drug resistant bacteria. This article discusses organisms which are major factors in this problem and reviews steps health care providers can take to slow this evolutionary process.

The leading causes of otitis and sinusitis, *Streptococcus pneumoniae*, *Haemophilus influenzae* (nontypeable) and *Moraxella catarrhalis* are prime examples of the trend toward antibiotic resistance. As recently as 1971, all three of these organisms were universally susceptible to ampicillin. At present, 75-100% of middle ear isolettes of *M. catarrhalis* and 20-35% of nontypeable *H. influenzae* are resistant to penicillin by production of a beta-lactamase.¹ Although *H. influenzae* Type B has rapidly developed production of a beta-lactamase, the current vaccine has significantly limited its morbidity and mortality.

S. pneumoniae is a leading cause of otitis and a prominent cause of invasive diseases such as pneumonia, sepsis and meningitis. Its resistance to penicillin through alterations of its penicillin-binding proteins on the cell surface has become a worldwide concern. This alteration in penicillin-binding proteins also contributes to its evolving resistance to other antibiotics, including the broad spectrum

cephalosporins. *S. pneumoniae* resistance can be intermediate (MIC 0.1-1.0 mcg/ml) or high (MIC greater than 2 mcg/ml). In the U.S., about 7% of invasive isolettes show some degree of resistance. The rates among nasopharyngeal isolettes from Tennessee and Kentucky tended to be much higher, 29% and 33% respectively.²

In the past, poor compliance with medication was the leading cause of medication failure when treating tuberculosis. Now, this problem is compounded by isolettes resistant to both isoniazid and rifampin: 3.5% nationwide and 14% in New York City.³ These two drugs have formed the backbone of all tuberculosis treatment regimens and there are few alternative antibiotics.

Staphylococcus aureus which, prior to 1941, was universally susceptible to penicillin, is a leading cause of nosocomial infections. Now, nearly all *S. aureus* are resistant to penicillin and many hospital isolettes are susceptible only to vancomycin or related glycopeptide.

Neisseria gonorrhoeae, enterococci and several gram negative enterics are other significant pathogens developing a high level of antibiotic resistance.

Many different mechanisms are involved in development of antimicrobial resistance. These mechanisms are the never-ending adaptations to the selective pressure from antibiotics. Unless a concerted effort is made by all health care providers, increases in morbidity, mortality and health care expenditures will continue. Physicians have an obligation to limit the emergence of resistance. There are several effective measures that must be taken.

No antibiotics should be prescribed for the treatment of a viral illness (ie, common cold, influenza). Unfortunately, most diagnoses of

The IMS Education Fund has designated this article as the Henry Albert Scientific Presentation Award for March 1995.

STEPHEN RINDERNECHT, DO
Dr. Rinderknecht is a pediatrician with Iowa Physicians Clinic in West Des Moines.

Antibiotic resistance: an emergency we can't ignore

continued

upper respiratory tract infection result in a prescription for amoxicillin. Resist the temptation to prescribe an antibiotic for these conditions and take time to educate the patient and discuss symptomatic care and relief.

Antibiotic prophylaxis should be reserved for specific clinical situations. Prophylaxis for surgical wounds should be limited to infection-prone body sites or in patients at high risk for infection (ie, abnormal heart valve). The antibiotic should be timed so the blood level peaks at the time of the procedure and limited to short duration. Several specific medical conditions which warrant antibiotic prophylaxis include:

1. Abnormal urinary tract anatomy or function predisposing to urinary tract infection.
2. Recurrent acute otitis media.
3. Past history of rheumatic fever.
4. Close contact with specific pathogens including:
 - *Haemophilus Influenza* Type B
 - *Neisseria meningitidis*
 - Tuberculosis
 - Pertussis
5. High risk procedures (ie, dental) in patients at risk for subacute bacterial endocarditis.
6. Dirty bite wounds, human and cat bites.
7. Immune suppressed (ie, chemotherapy, asplenic).
8. Neonatal ophthalmia.

There are many ways the narrowest spectrum of antibiotic can be best utilized. Penicillin remains effective for treatment of Group A beta-hemolytic strep, and should be considered the treatment of choice.^{4,5} Although many of the new oral cephalosporins are effective in eradicating the organism from the posterior pharynx, they lack any clinical advantage. The expense and unneeded broad spectrum of activity should limit their use in treating this common infection.


When minimal inhibitory concentrations (MICs) are available on an isolate, they should be used to select the narrowest spectrum antibiotic. These same principles apply to IV administered antibiotics in the hospital. Hospital epidemiologists have closely followed trends in nosocomial infections involving antibiotic resistant bacteria. This evolving problem in the hospital setting has led to the development of antibiotic restriction policies by many hospital

infection control committees.

Amoxicillin remains the drug of choice for initial empiric treatment of otitis media. The new broad spectrum antibiotics have demonstrated no therapeutic advantage. Treatment for beta-lactamase producing organisms or resistant *S. pneumoniae* should be considered only when amoxicillin has failed.

If antibiotics are to remain viable treatment choices in the future, more prudent use will be required. The effects of antibiotic use goes beyond the individual to the entire community.

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What a difference a generation makes

It may seem that consideration of managed care and the treatment of infections have no relationship. They do; for both underscore the tremendous changes during the past decades. The physicians in practice today face entirely different situations than those of my generation.

In the late 1940s and early 1950s, antimicrobials first became our closest ally in fighting infections. From the introduction in 1935 of the red sulfonamide—prontosil—to the exotic antibiotics of today, innumerable lives have been saved. The triumphs of the use of prontosil in the treatment of puerperal sepsis ranks with the advances in antisepsis promulgated by Lister.

Though Fleming is credited with the discovery of penicillin in 1929, it was not until 1940 that Chain, Flory and associates were able to produce significant quantities of penicillin for clinical use. By 1949 the supply of the "wonder drug" was unlimited. Subsequently, penicillins and cephalosporins became a large family sharing features of chemistry, mechanism of action, pharmacologic and chemical effects as well as immunologic characteristics. In turn we witnessed the introduction of various sulfonamide derivatives, tetracyclines, chloramphenicol, aminoglycosides, polymyxin and on and on.

Penicillin came into general use during my senior year of medical school (1948), and it has been wonderful to see introduction of the other

infection-fighting agents.

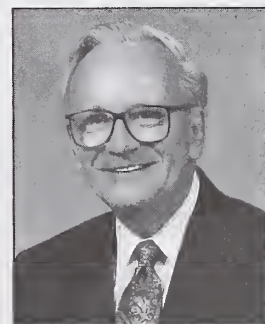
As indicated in Rinderknecht's article on page 127 and editorialized in the September 1994 issue of *South Dakota Journal of Medicine* the major problem in the use of antimicrobial agents is the ever increasing incidence of resistance by many prevailing organisms. Our most valuable tools are becoming a source of increasing problems. A recent article in *JAMA* (January 18, 1995) indicates that office-based physicians are prescribing more expensive broad-spectrum antibiotics. Some help comes with new vaccines, (e.g. hemophilus) but still there are many infections that are difficult to combat.

What of the business of medical practice?

The way our offices operate also has undergone striking change. From the simple methods used by the receptionist/bookkeeper five decades ago we now have complex office management challenges as well as the skills to deal with them. Third parties have intruded into the doctor-patient direct relationship. In order to compete, the ubiquitous computer has become as important as the stethoscope.

The physicians of today face hurdles and they too will conquer them. Accept new methods of practice—business as well as clinical—and our profession shall remain an honorable one. But, use the methods judiciously. **IM**

**To compete,
the ubiquitous
computer has
become as
important as
the stethoscope.**



MARION ALBERTS, MD

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Inflict kindness

For several fall semesters I've had the pleasant responsibility to meet weekly with a small group of freshman and another group of sophomore medical students. I gain the strong impression from these contacts that, in general, what they seek for their medical careers and their lives is "to take care of sick people," not "to be a health care provider who sells health care products to health care consumers." Cynics contend those statements are equivalent. I strongly disagree.

Cynics also argue that "detached concern," long considered a happy description for the relationship physicians should seek with their patients, refers to concern that students bring to their formal medical education, where faculty members then teach them detachment. I partially disagree. Yes, young students come bearing a large supply of willing altruism, but some of it must be characterized as too naive, not realistic. The world's a tough place and gradually one understands that inflicting kindness on people often won't succeed.


Taking care of the sick sometimes means curing, but always should mean attempting to reduce suffering. Technical competence is a must. And a world that includes, inevitably, material shortages of everything (except perhaps death and taxes) must add some sharp edges to what might otherwise remain a ball of warm fuzzies, comfy but ineffectual. Attaining the happy balance, as with so many things, is what's crucial.

As our attention fastens increasingly on cost containment and a hostile legal-regulatory climate, it becomes even harder to avoid the depersonalization that has been increasing in the medical world. But a recent advertisement makes a good point: "The last word in managed care is still care." It also dares to suggest, however, that "managed care" might more honestly be termed "managed cost," since the concerns often lie more with cost than care. But that's the cynics talking again.

The Latin origin of the word "patient" derives from the verb "to suffer." If we would mitigate suffering effectively enough, the sufferer would cease being a patient; but true to say, doctors, collectively, will never be out of work, because there's a potentially infinite supply of suffering.

**Our focus is
thus transformed from
helping a
sufferer to
making a sale.**

Whenever medical practices become more a business enterprise than a public service, the "patient" becomes a "customer"; our focus is thus transformed from helping a sufferer to making a sale. The language we use not only reflects our reality but shapes it.

A bumper-sticker recently urged me to "commit random acts of kindness." It's a variation of "inflict kindness." It's also good counsel. Such acts should be, I submit, not only random regarding time, place and recipient, but should be largely spontaneous. The joy, or at least the satisfaction they yield will tend to make one commit other such acts. Our world can always use more of them. 



RICHARD CAPLAN, MD

Classified Advertising

Mankato Clinic, Ltd.—A progressive group practice is seeking additional BE/BC physicians in the following specialties: family practice, invasive cardiology, oncology/hematology, orthopedic surgery and general internal medicine practice. The Mankato Clinic is a 65-doctor multispecialty group practice in south central Minnesota with a trade area population of +250,000. Guaranteed salary first year, incentive thereafter with full range of benefits and liberal time off. For more information, call Roger Greenwald, Executive Vice President, at 507/389-8500 or Anthony C. Jaspers, President, at 507/726-2136 or write 1230 East Main Street, P.O. Box 8674, Mankato, Minnesota 56002-8674.

Family Practitioner—McFarland Clinic is actively recruiting a BE/BC family practice physician to assume the responsibilities of an established family medicine practice in central Iowa. Practitioner has support of over 80 medical and surgical sub-specialty physicians in same multispecialty group. Full privileges for a residency-trained family physician at Mary Greeley Medical Center, a 200-bed hospital in Ames, Iowa. Night call on a rotating basis at the Emergency Room at MGMC. McFarland Clinic offers distinct advantages for the practicing physician in providing excellent compensation and benefits, practice management services and a generous retirement program, all in an environment which emphasizes physician cooperation and teamwork. For additional information, call or submit CV to Karen Andersen, 515/239-4535, McFarland Clinic, P.C., 1215 Duff Avenue, Ames, Iowa 50010.

Marshalltown, Iowa

Best of both worlds—rural small group atmosphere, urban large group amenities. Seeking quality emergency physicians interested in stellar emergency medicine practice. Full-time and regular part-time. 12K volume/12-hour shifts. Democratic group, highly competitive compensation, paid St. Paul malpractice with unlimited tail, excellent benefit package/bonuses for full-time. Numerous other Iowa locales. **ACUTE CARE, INC.**, P.O. Box 515, Ankeny, Iowa 50021; 800/729-7813 or 515/964-2772.

General Surgeon, Creston, Iowa—An opening for a third BC/BE surgeon in a very busy general surgery practice located 1 hour from Des Moines, Iowa. Two-surgeon department, expanding to 3 due to work load, is associated with 13 other physicians. Salary and benefit package very lucrative including moving expenses and full partnership within 1 to 2 years with limited call duty. Country living in a community of 9,000 with excellent educational system, recreation, low crime rate and lifestyle not found in metro areas. Contact Mike Brentnall, 515/782-2131 or send CV to Creston Medical Clinic, PC, 526 New York Avenue, Creston, Iowa 50801.

Locum Tenens Emergency Medicine

Seeking quality physicians interested in emergency medicine practice or primary care locum tenens. Full-time and regular part-time. Numerous Iowa locales. Democratic group, highly competitive compensation, paid St. Paul malpractice with unlimited tail, excellent benefit package/bonuses to full-time physicians. Contact **ACUTE CARE, INC.**, P.O. Box 515, Ankeny, Iowa 50021. Phone 1-800/729-7813 or 515/964-2772.

Family Practice—Leading 300+ physician group based in southwestern Wisconsin seeks additional family practitioners for established branch clinics in Wisconsin and Iowa. Attractive group practices offer a professional and stimulating environment with shared call coverage, modern local hospitals, strong specialty network and competitive compensation package. Practice settings vary from a scenic college town to a picturesque Mississippi River community. For details, call Mike Krier at 1/800-243-4353.

Emergency Medicine, Des Moines, Iowa—Opportunity to join an established emergency medicine practice at Iowa Lutheran, member of the Iowa Health System. BE/BC in emergency medicine or primary care specialty with experience. Call me to learn more about our department and generous compensation package. Contact Larry J. Baker, DO, FACEP, 700 E. University, Des Moines, Iowa 50316; 515/263-5263.

General Faculty, Department of Family Practice, University of Iowa College of Medicine—The University of Iowa Department of Family Practice offers full-time faculty positions for residency-trained, ABFP certified family physicians. Obstetric skills and previous teaching experience highly desirable. Additional faculty needed to address new primary care initiatives. As a part of a full academic department, responsibilities include teaching, research and patient care. Well-established, 24-resident program is university-administered, community-based, and has admissions at community and university hospitals. A new model office facility is being built. Well-established department with special strengths in its clinical and behavioral science faculty. As a "Big Ten" university community, Iowa City is a great place to live. Appointment and salary commensurate with qualifications and experience. The University of Iowa is an Equal Opportunity and Affirmative Action employer. Women and minorities are strongly encouraged to apply. Submit a letter of interest and CV to Gerald J. Jogerst, MD, Interim Department Head, Department of Family Practice, 2149 Steindler Building, Iowa City, Iowa 52242-1097; 319/335-8454.

Minneapolis, MN—Opportunities available for BE/BC family practitioners with OB to join 6 person group. Western Minneapolis suburb. No practice buy-in required. Excellent salary and benefits. Please send CV or call Nancy Borgstrom, Aspen Medical Group, 1021 Bandana Boulevard East #200, St. Paul, Minnesota 55108, 612/642-2779 or fax 612/642-9441. EOE.

Primary Care Physicians and Subspecialists—Are being sought for a variety of group practices located throughout the upper Midwest and New York state. Choose from metropolitan cities, college towns, popular resort communities or traditional rural distinctions. This month, opportunities available for physicians specializing in family practice, internal medicine, pediatrics, occupational medicine, hematology/oncology and nephrology. New opportunities monthly! For all of the facts, call 800/243-4353 or write to Strelcheck and Associates, 10624 North Port Washington Road, Mequon, Wisconsin 53092.

LeMars, Iowa

Seeking quality physicians to practice at a 4300 average volume ER. Director and staff positions. Full and regular part-time. Democratic group, highly competitive compensation, paid St. Paul malpractice with unlimited tail, excellent benefit package/bonuses to full-time physicians. **ACUTE CARE, INC.**, P.O. Box 515, Ankeny, Iowa 50021; phone 800/729-7813.

Internal Medicine, Carroll, Iowa—Outstanding professional opportunity for an internal medicine physician in a progressive, safe and clean community of 10,000. This opportunity is available for either practicing internal medicine physician, or the internal medicine physician just beginning practice. Excellent schools (Catholic and public), quality hospital and significant income potential available. For more information, call Randy Simmons, vice president, at 1-800/382-4197 or write St. Anthony Regional Hospital, South Clark Street, Carroll, Iowa 51401.

Sioux City—An excellent position is available for a BC/BE family practice physician in a new community health center. A full range of family practice medicine is needed in a community that is very supportive of the center. Sioux City is a great place to raise a family and has excellent public and parochial school systems, a community college, 2 liberal arts colleges, a graduate center, 2 excellent medical centers, a Residency Training Program (family practice), etc. The center offers a competitive compensation and benefit package, paid malpractice, etc. **FEDERAL LOAN REPAYMENT PROGRAM AVAILABLE.** For more information write Jeff Hackett, Executive Director, Siouxland Community Health Center, PO Box 2118, Sioux City, Iowa 51104-0118 or call 712/252-2477.

Not Just Another Recruitment Ad—Opportunities at North Memorial-owned and affiliated clinics will give you a shot of adrenaline because we practice in a care management environment that FPs, IMs and OB/GYNs thrive on. Guide your patients through their entire care process at one of our 25 clinics in urban or semi-rural Minneapolis locations. Plus, become eligible for \$15,000 on start date. Interested BC/BE MDs, call 1/800-275-4790 or fax CV to 612/520-1564.

Family Practice, Carroll, Iowa—Outstanding professional opportunity for family practice physicians in a progressive, safe and clean community of 10,000. These opportunities are available for either experienced family practice physicians, or the family practice physician just beginning practice. Excellent schools (Catholic and public), quality hospital and significant income potential available. For more information, call Randy Simmons, Vice President, at 1-800/382-4197 or write St. Anthony Regional Hospital, South Clark Street, Carroll, Iowa 51401.

Lighted Slide Storage System—Stores 1000+ slides on illuminated racks. Find any slide quickly and easily. Free catalog 800/950-7775.

Boone, Iowa

Seeking a quality emergency physician interested in a stellar emergency medicine practice. Full and regular part-time position available. Democratic group, paid St. Paul malpractice with unlimited tail. Excellent benefit package/bonuses to full-time physicians. Average volume with above-average compensation. **ACUTE CARE, INC.**, P.O. Box 515, Ankeny, Iowa 50021; phone 800/729-7813.

Faculty position—For a well-established community-based family practice program in Davenport, Iowa, affiliated with the University of Iowa. Seeking board certified family physician to join 3 other full-time family physicians, a clinical pharmacist, a behavioral science coordinator and our program administrator in a team approach to practicing and teaching the full range of family medicine. Our program emphasizes a true individual family practice experience for each resident in parallel to subspecialty experience with enthusiastic community preceptors. Faculty is encouraged to develop individual special interests and the chance to share their experience with physicians in training. Davenport is part of the Quad Cities, a large metropolitan area centered in the Mississippi Valley on the Illinois and Iowa border. Excellent school system. Experience in practice or teaching valuable but not required. Obstetrics required. Excellent benefit package, competitive salary commensurate with experience. Contact Monte L. Skaufler, MD, Director, Quad Cities Genesis Family Practice Residency Program, 516 W. 35th Street, Davenport, Iowa 52806.

Advertising Rates and Data

Regular classified advertising sells for \$2.00 per line with a \$30 minimum per insertion. For members of the Iowa Medical Society the rate is \$20 per insertion. Display classified advertising sells for \$25 per column inch, per month. Sizes range from 1 column by 2 inches to 1 column by 6 inches. A variety of type sizes, borders, reverses or screens can be included in the ad. Blind box numbers are available upon request at no additional charge. Copy deadline is the 1st of the month preceding publication. Send or fax copy to Iowa Medicine, 1001 Grand Avenue, West Des Moines, Iowa 50265-3599, fax 515/223-8420.

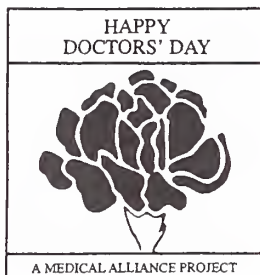
Family Practice Physician—Rare opportunity for a BE/BC family practice physician to join an established, progressive 8-physician practice in Marshalltown, Iowa, a thriving family oriented community 40 miles northeast of Des Moines. We have a beautiful new facility, a qualified staff and enjoy a supportive relationship with our 176-bed local hospital. Our philosophy is to provide personal, quality care to each of our patients, while maintaining our productivity, profitability and efficiency. This position offers an excellent benefit package, a voice in decision-making, 1 in 8 call and a very competitive salary/dividend package. For more information call or write to Michael Miriovsky, MD or James Burke, MD, Center for Family Medicine, PLC, 312 E. Main Street, Marshalltown, Iowa 50158 or call 515/752-5469.

Time For a Move?—BC/BE FP, IM, OB/GYN, PEDS. Our promise—We'll save you valuable time by calling every hospital, group and ad in your desired market. You'll know every job within 20 days. We track every community in the country, including over 2000 rural locations. Cedar Rapids, Des Moines, Quad Cities, Kansas City, Boston, Chicago, Indianapolis, many more. New openings daily—call now for details! The Curare Group, Inc., M-F 9am-8pm, Sat 1-5 pm EST. 800/880-2028, Fax 812/331-0659.

Emergency Medicine, Council Bluffs, Iowa—Opening available for qualified physician to join group of emergency physicians. Training and/or certification in primary care specialty or emergency medicine. Flexible scheduling. Newly remodeled emergency department. Enjoy rural and urban atmosphere. Compensation up to +\$200K/year plus vacation. Write Bluffs Emergency Care Services, PC, 933 East Pierce Street, Council Bluffs, Iowa 51503; 712/328-6111.

DOCTORS' DAY

MARCH 30



Doctors' Day originated in 1933 in Georgia by Mrs. Charles Almond. Mrs. Almond was inspired by the dedication and outstanding achievements of physicians.

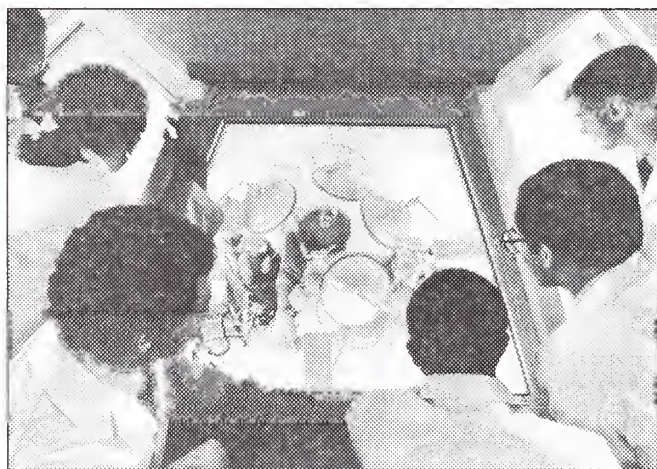
March 30 was chosen as the date for observing Doctors' Day because it commemorates one of the greatest discoveries in medicine. On March 30, 1842, Dr. Crawford Long first used ether as an anesthetic in a surgical operation thereby providing mankind with freedom from pain and suffering during surgery.

The first Doctors' Day commemoration in Iowa was in 1957. The purpose of Doctors' Day is to honor members of the medical profession. The true objective of the observance is to pay tribute to the physician for services rendered in the community.

On March 30, 1958, a resolution commemorating Doctors' Day was adopted by the United States House of Representatives. On October 30, 1990, President George Bush signed a joint resolution into law designating March 30 as National Doctors' Day.

The red carnation is the official symbol of Doctors' Day. The Iowa Medical Society Alliance takes great pride in saluting our doctors that serve the community, not only on Doctors' Day, but everyday.

AN ARMY SCHOLARSHIP COULD HELP YOU THROUGH MEDICAL SCHOOL



The U.S. Army Health Professions Scholarship Program offers a unique opportunity for financial support to medical or osteopathy students. Financial support includes tuition, books, and other expenses required in a particular course.

For information concerning eligibility, pay, service obligation and application procedure, contact the Army Medical Department Personnel Counselor:

CPT. RHONDA HOWARD 1-800-347-2633

ARMY MEDICINE. BE ALL YOU CAN BE.®

Merrill, Wisconsin Family Practice

When you join a practice in Merrill, Wisconsin, you'll be close to what is important to you: your practice and your family.

A practice in Merrill, Wisconsin means you're in the middle of safe, thriving areas offering diverse commercial interests, cultural variety, all-season recreation, and highly-rated school systems. You will receive a wide range of benefits including an excellent compensation package while practicing in a smaller, personalized environment.

We offer a lot and would like to also tell you what we don't offer: high cost of living, pollution, crime, congestion, and traffic.

For more information on Merrill, Wisconsin, please contact:

Sam Holte, 1-800-766-7765.

FAX: (715) 847-2984.

Wausau Regional Health-care, Inc., 3000 Westhill Dr., Suite 202, Wausau, Wisconsin 54401.



Wausau Regional Health Care, Inc.
Divisions: Methodist Clinic • Monroe Family Clinic

LA CROSSE WISCONSIN

- Live in beautiful Mississippi River Valley.
- Work with high quality colleagues in growing multispecialty group (70 physicians).
- Competitive income/benefits.

SPECIALISTS NEEDED

Cardiology (Non-Invasive)
Critical Care/Pulmonary Medicine
Dermatology
Emergency Medicine
Family Practice
Internal Medicine
Neurology
Occupational Medicine
Orthopedic Surgery
Pediatrics
Urology

Send CV to: **P. Stephen Shultz, M.D.**
SKEMP CLINIC
800 West Avenue South
La Crosse, Wisconsin 54601
Fax 608/791-9898 or
Phone 608/791-9844, ext. 6329

You'll know your career is on the rise when ■■■■■

...**You** customize your practice to your interests...You receive productivity based compensation with excellent 1st year income guarantee...Consolidated organization of our 50+ physician multispecialty practice frees you from both office management and buy-in costs...Our comprehensive benefits give you at least 5 weeks vacation/CME time, malpractice, health, life, disability and dental insurances, and \$3750 CME allowance...You join The Monroe Clinic—a consolidated outpatient and inpatient healthcare facility combining a new 114,000 sq.ft. clinic and adjoining 140-bed acute care hospital with 24 hr. ER coverage serving south central WI and northern IL. We have openings for BC/BE physicians in:

- Family Practice
- OB/GYN
- Cardiology (non-invasive)
- Outpatient Psychiatry
- Orthopedic Surgery
- Pulmonology
- Dermatology

You'll like the friendly neighbors and neighborhoods in four-season Monroe, Wisconsin, a family-centered rural community of 10,000 located just one hour from Madison, WI, Dubuque, IA, and Rockford, IL...and two hours from Chicago and Milwaukee. We enjoy excellent schools, a thriving economy, solid values, an abundance of parks and recreation centers, popular entertainment and shopping facilities, and easy access to nearby universities.

For more information write or call: **Physician Staffing Specialist, THE MONROE CLINIC, 515 22nd Ave., Monroe, WI 53566. 800-373-2564. Or fax resume to: 608/328-8269. EOE.**



The Monroe Clinic
A proud caring tradition

Unique Surgical Opportunity

Estherville, Iowa (population 7,500) is seeking a general surgeon. Northwest Iowa location in the Lakes Region with outstanding outdoor recreation. Six referring family practice physicians. Minimal managed care. For more information contact:

Tom Nordwick, CEO
Holy Family Hospital
826 North 8th Street
Estherville, Iowa 51334-1598
712/362-2631

Professional Listing

Allergy

John A. Caffrey, MD, PC
1212 Pleasant, Suite 106
Des Moines 50309
515/243-0590
Allergy & Immunology

Allergy Institute, PC
A.Y. Al-Shash, MD
R.K. Agarwal, MD
1701 22nd Street, Suite 201
West Des Moines 50266
515/223-8622

Pediatric and Adult Allergy, PC
Veljko K. Zivkovich, MD
Robert A. Colman, MD
1212 Pleasant, Suite 110
Des Moines 50309
515/244-7229
Asthma, Allergy & Immunology

Dermatology

Robert J. Barry, MD
1030 Fifth Avenue, SE
Cedar Rapids 52403
319/366-7541
*Practice Limited to Disease,
Cancer and Surgery of Skin*

Fort Dodge Medical Center, PC
Carey A. Bligard, MD, FAAD
James D. Bunker, MD, FAAD
800 Kenyon Road
Fort Dodge 50501
515/574-6850

Electrodiagnosis

John Milner-Braçe, MD
208 St. Francis Professional Building
Waterloo 50702
319/234-6446
*Electromyography & Nerve
Conduction Studies
Certified by American Board of
Electrodiagnostic Medicine*

Emergency Medicine

Acute Care, Inc.
P.O. Box 515
Ankeny 50021
515/964-2772 or 1-800/729-7813
*Comprehensive Emergency Medicine
Practice, Locum Tenens,
Doctor on Call*

Emergency Practice Associates
P.O. Box 1260
Waterloo 50704
1-800/458-5003
*Specialists in Emergency
Staffing & Emergency Department Services*

Family Practice

Acute Care, Inc.
P.O. Box 515
Ankeny 50021
515/964-2772 or 1-800/729-7813
*Locum Tenens
Doctor on Call*

Infectious Diseases

**Chest, Infectious Diseases & Critical Care
Associates, PC**
Daniel H. Gervich, MD
Daniel J. Schroeder, MD
Ravi K. Vemuri, MD
Infectious Diseases
1601 NW 114th, Suite 347
Des Moines 50325-7072
24 Hours 515/224-1777

Infertility

Mid-Iowa Fertility, PC
Donald C. Young, DO
3408 Woodland Avenue, Suite 302
West Des Moines 50266
515/222-3060
*Reproductive Endocrinology/Infertility
IVF and GIFT Procedures
Donor Oocyte Program
Artificial Inseminations
Reproductive Surgery
Menopause Management*

Internal Medicine

Fort Dodge Medical Center, PC
Cardiology
Samir G. Artoul, MD, FICC
515/574-6840
Gastroenterology
Kenneth W. Adams, DO, AOBIM
General Internal Medicine
William C. Robb, MD
Richard H. Brandt, MD, ABIM
Grace Z. Ang, MD
800 Kenyon Road
Fort Dodge 50501
515/574-6820

Neurology

Iowa Medical Clinic Neurology
Andrew C. Peterson, MD
Laurence S. Krain, MD
600 7th Street SE
Cedar Rapids 52401
319/398-1721
*Neurology, EEG, EMG, Evoked Potentials
and Sleep Studies*

Fort Dodge Medical Center, PC
Jugal T. Raval, MD, MBBS
800 Kenyon Road
Fort Dodge 50501
515/574-6845

Neurosurgery

**Iowa Medical Clinic
Neurosurgery**
James R. Lamorgese, MD
600 7th Street, SE
Cedar Rapids 52401
319/366-0481
Practice limited to Neurosurgery

Hosung Chung, MD
2710 St. Francis Drive, Suite 401
Waterloo 50702
319/232-8756; fax 319/232-5703
Practice limited to Neurosurgery

Neurosurgical Services LLP

Robert Hayne, MD
Thomas A. Carlstrom, MD
David J. Boarini, MD
 1215 Pleasant, Suite 608
 Des Moines 50309
 515/241-5760

Robert C. Jones, MD
S. Randy Winston, MD
Douglas R. Koontz, MD
 2600 Grand Avenue, Suite 210
 Des Moines 50312
 515/283-2217

Neurological Surgery

Chad D. Abernathey, MD
 1953 1st Avenue SE
 Cedar Rapids 52402
 319/363-4622

Neurological Surgery

Obstetrics/Gynecology**Fort Dodge Medical Center, PC**

Brian L. Welch, MD
 800 Kenyon Road
 Fort Dodge 50501
 515/574-6870

Ophthalmology

Wolfe Clinic, PC
Russell H. Watt, MD
John M. Graether, MD
Gilbert W. Harris, MD
James A. Davison, MD
Norman F. Woodlief, MD
Eric W. Bligard, MD
David D. Saggau, MD
Steven C. Johnson, MD
Todd W. Gothard, MD
 309 East Church
 Marshalltown 50158
 515/754-6200

Satellite Offices

Lakeview Medical Park
 6000 University Avenue, Suite 300
 West Des Moines 50266
 515/223-8685

804 South Kenyon Road, Suite 100
 Fort Dodge 50501
 515/576-7777

Sartori Professional Building
 516 South Division Street
 Cedar Falls 50613
 319/277-0103

214 - 13th Street Southeast
 Cedar Rapids 52403
 319/362-8032

Ophthalmic Associates, PC

Robert D. Whinery, MD
Stephen H. Wolkstein, MD
Robert B. Goffstein, MD
Lyse S. Strnad, MD
 540 E. Jefferson, Suite 201
 Iowa City 52245
 319/338-3623

North Iowa Eye Clinic, PC
Addison W. Brown, Jr., MD
Michael L. Long, MD
Bradley L. Isaak, MD
Randall S. Brenton, MD
James L. Dummert, MD
 3121 4th Street, S.W.
 P.O. Box 1877
 Mason City 50401
 515/423-8861

Timothy F. Moran, Jr., MD
 United Federal Building
 700 4th Street, Suite 305
 Sioux City 51101
 712/252-4333

Satellite Clinics

Horn Memorial Hospital
 700 E. 2nd Street
 Ida Grove 51445
 712/364-3311

Orange City Hospital
 400 Central Avenue NW
 Orange City 51041
 712/737-2426

General Ophthalmology

Orthopaedics

Iowa Orthopaedic Center, PC
Marvin H. Dubansky, MD
Marshall Flapan, MD
Sinesio Misol, MD
Joshua D. Kimelman, DO
Timothy G. Kenney, MD
Lynn M. Lindaman, MD
Jeffrey M. Farber, MD
Kyle S. Galles, MD
Scott A. Meyer, MD
Cassim M. Igram, MD
Donna J. Bahls, MD
Jill R. Meilahn, DO
Jacqueline M. Stoken, DO
 411 Laurel, Suite 3300
 Des Moines 50314
 515/247-8400

Orthopaedic Surgery

Fort Dodge Medical Center, PC
C. Mark Race, MD
 800 Kenyon Road
 Fort Dodge 50501
 515/574-6880

Otolaryngology

Iowa ENT, PC
Thomas A. Ericsen, MD
Marshall C. Greiman, MD
Steven R. Herwig, DO
Thomas O. Paulson, MD
Mark K. Zlab, MD
 1-800/248-4443
 1215 Pleasant, Suite 408
 Des Moines 50309
 515/241-5780

1200 35th Street, Suite 200
 West Des Moines 50266
 515/225-7761
 Satellite Clinics:

*Pella, Perry, Newton, Indianola,
 Oskaloosa, Guthrie Center, Knoxville*

Wolfe Clinic, PC
Michael W. Hill, MD
Daniel J. Blum, MD
 309 East Church
 Marshalltown 50158
 515/752-1566

Lakeview Medical Park
 6000 University Avenue, Suite 310
 West Des Moines 50266
 515/224-9533

Sartori Professional Building
 516 South Division Street
 Cedar Falls 50613
 319/277-3105

*Otolaryngology-Head and Neck Surgery,
 Facial Plastic Surgery, Allergy*

Phillip A. Linquist, DO, PC
 1000 Illinois
 Des Moines 50314
 515/244-5225

*Ear, Nose and Throat Surgery,
 Facial Plastic Surgery, Head
 and Neck Surgery*

(Continued next page)

Professional Listing Rates

Physician members of the Iowa Medical Society may advertise in this directory. Monthly rates are as follows: \$10.00 first 3 lines; \$2.00 each additional line. Billed yearly. May be prorated. Send or fax copy to Iowa Medical Society, 1001 Grand Avenue, West Des Moines, Iowa 50265-3599, fax 515/223-8420.

Iowa Head and Neck Associates, PC

Robert T. Brown, MD
Eugene Peterson, MD
Richard B. Merrick, MD
Peter V. Boesen, MD
Robert R. Updegraff, MD
 3901 Ingersoll
 Des Moines 50312
 515/274-9135

Dubuque Otolaryngology-Head & Neck Surgery, PC

Thomas J. Benda, Sr., MD
James W. White, MD
Craig C. Herther, MD
Thomas J. Benda, Jr., MD
 310 North Grandview Avenue
 Dubuque 52001
 319/588-0506

Otologic Medical Services, PC

Roger A. Simpson, MD
Guy E. McFarland, MD
Thomas F. Vincir, MD
Douglas E. Dawson, MD
 540 E. Jefferson, Suite 401
 Iowa City 52245
 319/351-5680
 1-800/642-6217
Maxillofacial, Plastic, Head & Neck Surgery

Robert G. Smits, MD, PC

1040 5th Avenue
 Des Moines 50314
 515/244-8152
 1-800/622-0002
*Ear, Nose and Throat Surgery,
 Facial Plastic Surgery and Head and Neck Surgery*

Pain Management**Iowa Medical Clinic Outpatient Pain Treatment Center**

James R. LaMorgese, MD, FACS,
Neurosurgeon, Medical Director
Sandra Gannon, LSW, ACSW, Program Director
 600 7th Street SE
 Cedar Rapids 52401
 319/399-2013
Neurology, Psychiatry, Anesthesiology, Rheumatology

Perinatology**Des Moines Perinatal Center, PC**

Neil T. Mandsager, MD
 3408 Woodland Avenue, Suite 302
 West Des Moines 50266
 515/222-3060
*Maternal-Fetal Medicine
 Routine and Advanced (Level II)
 Obstetric Ultrasound
 Genetic Counseling
 Amniocentesis and CVS
 Antenatal Testing
 High-Risk Obstetrical Management
 High-Risk Deliveries*

Physical Medicine & Rehabilitation**Genesis Regional Rehabilitation Center**

Genesis Medical Center
 1227 East Rusholme Street
 Davenport 52803
 319/383-1466
Maurice D. Schnell, MD
Farcedduddin Ahmed, MD
Arthur B. Searle, MD
Bogdan E. Krysztofiak, MD

Rehabilitation Medicine Associates

William D. deGravelles, Jr., MD
Charles F. Denhart, MD
Marvin M. Hurd, MD
William C. Koenig, Jr., MD
Karen Kienker, MD
Todd C. Troll, MD
Lori A. Sapp, MD
Yunker Rehabilitation Center
Iowa Methodist Medical Center
 1200 Pleasant
 Des Moines 50308
 515/241-6434

2600 Grand Avenue, Suite 102
 Des Moines 50312
 515/283-1570

Pulmonary Medicine**Fort Dodge Medical Center, PC**

Robert C. Ang, MD, FCCP
 800 Kenyon Road
 Fort Dodge 50501
 515/574-6820

Chest, Infectious Diseases & Critical Care Associates, PC

Roger T. Liu, MD
Steven G. Berry, MD
Donald L. Burrows, MD
Michael Witte, DO
Gerard A. Matysik, DO
 1601 NW 114th, Suite 347
 Des Moines 50325-7072
 24 Hour 515/224-1777
Pulmonary Diseases

Surgery**Wendell Downing, MD**

1212 Pleasant Street, Suite 410
 Des Moines 50309
 515/241-5767
Diseases and Surgery of the Colon and Rectum

Fort Dodge Medical Center, PC

Ralph E. Woodard, MD, FACS
Dan P. Warlick, MD, FACS
 800 Kenyon Road
 Fort Dodge 50501
 515/574-6865

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Helping our patients and our communities

Help for a medical student who needs financial aid to get through those last two years when the end still seems so far away. A teen crisis Careline card for a high school student with failing grades and an abusive parent. These are examples of situations where Iowa physicians have picked up the yoke to help move the wagon. Iowa physicians—through the IMS Education Fund—are helping make the load lighter. Medical students borrow money from the fund, pay a reasonable interest and—as they start earning—pay back the funds to enable other students to borrow. Only a handful of students over 25 years has defaulted. The Iowa Medical Society Education Fund, which exists because of contributions from Iowa physicians, is the largest source of private money to Iowa medical students.

Eight hundred and fifty three student loans have been made since the inception of the Education Fund. In 1994-95, \$265,000 has been allocated. The IMS Education Fund, which is also involved in physician education projects, helped support the January and February issues of *Iowa Medicine*, which were devoted to domestic violence.

Many requests are made to the Iowa Medical Society Education Fund for worthwhile projects. Some projects provide opportunities to promote our association and assist our patients that would not otherwise be available. This year a committee on fund-raising activities was appointed. It is comprised of past presidents of

our medical society. This committee will consider ways to increase the amount of contributions to the IMS Education Fund as well as the number of contributors. The first meeting was held January 10, chaired by Dr. Paul Seebohm. Other past presidents who attended were Dr. Donald Rodawig, Dr. John Tyrrell and Dr. Dennis Walter.

Some recommendations were to establish a short term financial goal, develop appropriate brochures/articles, target the audience, provide recognitions of various categories of givers and develop accurate information on ways to contribute to the Fund.

Through the IMS Education Fund, physicians have a vehicle to promote medicine in Iowa, gain a positive image and help our pa-

tients and communities in a positive way. We can do more united than we can alone. Please help your organization and yourself by contributing to the IMS Education Fund. **IM**

**Iowa
physicians
are helping
make the
load
lighter.**



JAMES WHITE, MD

IMS Update

AT A GLANCE

Don't forget to complete and return your survey on general format and location of the IMS House of Delegates meeting. The survey was enclosed with a letter regarding 1995 IMS elections which was mailed in early March to all IMS members. The survey can be returned by mail or by fax, 515/223-8420.

Two experts on telemedicine applications will be speaking at the final day of the Iowa Hospital Association Annual Meeting Thursday, April 27 at the Des Moines Marriott. There will also be a demonstration of the virtual hospital. Physicians are welcome to attend the plenary sessions which begin at 8:30 a.m. For more information, call Becky Anthony at the IHA, 515/288-1955.

House of Delegates weekend April 28-30

The focus will be on IMS policy on health care issues and developments in technology and treatment April 28-30 when Iowa physicians gather for the Iowa Medical Society's 1995 House of Delegates and Scientific Session at the Marriott Hotel.

The Scientific Session will begin at 8:00 a.m. Friday and will conclude with a Sunday morning panel discussion of domestic violence. Dr. Richard Corlin, vice speaker of the AMA House of Delegates, will be a special guest for the weekend's activities.

The House of Delegates will begin deliberations Saturday morning at 8:30 a.m. An orientation session for new delegates will be held at 7:30 a.m. The concluding session of the House will begin at 10 a.m. Sunday and will include election of officers.

Policy resolutions cover many subjects

As of press time, the following policy resolutions had been received:

1. COMMUNITY HEALTH MANAGEMENT INFORMATION SYSTEM (CHMIS) (*Introduced by District VIII*) — Asks that the IMS recommend to the CHMIS Governing Board that Blue Cross/Blue Shield be denied any future bid to become the state data repository for the CHMIS network.

2. ADMINISTRATIVE SUPPORT FOR SPECIALTY SOCIETIES (*Introduced by District VIII*) — Asks that the IMS, via its wholly-owned subsidiary IMS Services, market its capability to provide administrative services to state specialty societies on a fee-for-service basis.

3. FUTILE CARE (*Introduced by Districts X & XI*) — Asks that IMS delegates to the AMA strongly encourage AMA to develop community guidelines to determine when care is appropriate at the end of life while maintaining patient dignity and physician integrity.

4. ABOLISHMENT OF GPCIS (*Introduced by Districts X & XI*) — Asks the IMS to send a resolution to the 1995 AMA House of Delegates requesting them to submit legislation providing for elimination of or more fairly calculated

Geographic Practice Cost Indices.

5. PEDIATRIC/ADOLESCENT MORBIDITY AND MORTALITY DUE TO FIREARMS (*Introduced by Districts X & XI*) — Asks the IMS to establish a task force on violence intervention and support legislation which reduces the availability of guns to children.

6. IMS ANNUAL MEETING DATE (*Introduced by Districts X & XI*) — Asks that the date of the annual IMS House of Delegates be set back to March.

7. STANDING COMMITTEE ON PERSONAL/FAMILY VIOLENCE (*Introduced by Districts X & XI*) — Asks the IMS to establish a standing committee on family/domestic violence and introduce unambiguous legislation regarding criminal domestic violence reporting requirements and the medical hospital law enforcement investigative cooperation process.

SPECIALTY SOCIETY UPDATE

The IMGMA Spring Meeting will be May 3-5 at the Des Moines Marriott. Board and committee chairs participated in a strategic planning session March 3-4. The second Management Education Program (MEP) will begin in May rather than March. More information will be mailed to IMS members soon. This is a great opportunity to learn administrative principles which will aid physicians in the managed care environment.

The Iowa Psychiatric Society Spring Meeting will be at the Des Moines Marriott April 7.

Newly elected to the American College of Cardiology, Iowa Chapter — Phillip Habak, MD, president-elect; Todd Langager, MD, secretary-treasurer. Council members are: Steven Phillips, MD; David Lemon, MD; Ellen Gordon, MD and Richard Menning, MD.

The Iowa Society of Anesthesiologists Spring Meeting was held April 1 at the Des Moines Convention Center. Norig Ellison, MD, president-elect of the American Society of Anesthesiologists, was keynote speaker.

The Oncology Society board meeting will be April 26 at the University of Iowa Hospitals and Clinics.

Coma stimulation and post-polio case presentations were discussed at the Iowa Society of Rehabilitation Medicine Spring Meeting April 7.

8. **INAPPROPRIATE REQUESTS FOR PHYSICIAN DEA REGISTRATION NUMBERS** (*Introduced by District II*) — Asks the IMS to remind physicians that the Drug Enforcement Agency registration number is intended to regulate the prescription of controlled substances and encourage physicians to report inappropriate requests to the Board of Pharmacy Examiners.

9. **IMPAC REPRESENTATION FOR RESIDENTS, STUDENTS** (*Introduced by District II*) — Asks that the IMS Board of Trustees appoint a resident and a medical student to serve on the Iowa Medical Political Action Committee Board.

10. **HIV TESTING, AIDS PREVENTION** (*Introduced by District II*) — Asks the IMS to support a number of initiatives regarding HIV and AIDS.

11. **SUPPORT PROGRAM FOR PHYSICIANS SUED FOR MALPRACTICE** (*Introduced by District I*) — Asks that the IMS develop a model support program for physicians being sued, and submit a resolution to the AMA asking for resources to support development of such a program.

12. **PENSION PROTECTION** (*Introduced by District III*) — Asks the IMS to adopt a policy that pension assets of federally qualified pensions be exempt from civil liability awards including malpractice suits and pursue legislation to that effect.

These resolutions and any others received before the meeting will be considered by reference committees before being presented to the full House of Delegates on Sunday. Reference committee deliberations will begin Saturday, April 29 at 1 p.m.

Reference committee hearings give IMS delegates and other physicians the opportunity to comment on resolutions before they are submitted for House action on Sunday.

Supplemental reports to House

The House of Delegates will also receive supplemental reports from the Board of Trustees and the IMS Committee on CHMIS. The Board report will discuss finances, *Iowa Medicine*, specialty society representation in the House of Delegates plus several articles and bylaws changes.

The IMS CHMIS Committee met April 4 and will report to the House on the activities of the CHMIS Governing Board and Advisory Committees and on a proposed IMS statement of principles.

Special events

- IMPAC will hold a reception Friday evening from 6:00 - 9:00 p.m. at the Marriott.
- David Werner, a political satirist from

Washington, DC will be the entertainment at the Saturday evening banquet. Newly-elected U.S. Congressman Greg Ganske, MD will be a special guest at the banquet.

Candidates for IMS offices named

The IMS Nominating Committee has assembled the following candidate slate for 1995-96 elections. The slate will be formally presented to the IMS House of Delegates on Saturday, April 29 and further nominations will be accepted from the floor. Elections will be held at the final House session Sunday.

Candidates for 1995-96 offices

President-elect (1-year term) — William McMillan, MD

Vice president (1-year term) — Hunter Fuerste, MD
and Sterling Laaveg, MD

Trustee (3-year term) — Siroos Shirazi, MD

Speaker, House of Delegates (1-year term) — Donald Kahle, MD

Vice speaker, House of Delegates (1-year term) — Tom Throckmorton, MD

AMA delegates (2-year terms, 2 will be elected) —

Clarkson Kelly, Jr., MD; and Daniel Youngblade, MD

AMA alternate delegates (2-year terms, 2 will be elected) —

Jeff Anderson, MD; Bernard Fallon, MD; Bryan Pechous, MD; Askar Qalbani, MD; and Mir Waziri, MD

District Councilors (3-year terms)

District 1 — Robert Kent, MD

District VI — John Justin, MD

District IX — Jay Heitsman, MD

District XIII — Linda Iler, MD 

FOCUS ON IMS ALLIANCE

The Alliance began its year poised for change, ready to meet challenges. We expected change to come in the form of sweeping government mandates, but it reached us in the form of forces driven by the marketplace. Many have been dragged along; some have been innovators.

This month brings us the annual meetings of the House of Delegates for both the IMS and IMSA. As we shift our focus, I encourage everyone to examine their own involvement. Now, more than ever, it is imperative that physicians and spouses become "One Voice, One Choice" for medicine. We can let change happen or make it happen. The choice is ours.

Contributed by Barbara Bell, president, IMSA

Futures

AT A GLANCE

President Clinton's budget was "kind" to Medicare and Medicaid, but some Democrats privately complained that it didn't go far enough in recommending spending cuts, primarily Medicare and Medicaid. Senator Bill Bradley, D-NJ, said he was disappointed the president's proposals did not go further in reducing the deficit.

In February, the IMS Board of Trustees met with officials of the Iowa Hospital Association. An IRS ruling in one non-profit hospital case where a PPO was limited to 20% physician representation was discussed; both groups agree that a true partnership would be 50-50. IMS board members meet every six months with IHA officials.

The IMS and IMGMA were cosponsors of a state data conference April 6. More information on the conference will appear in next month's Iowa Medicine.

Future at stake, say Iowa State economists

Two Iowa State University economists have issued a press release in which they say that our collective standard of living and economic opportunity for the next generation are at stake unless entitlement spending is brought under control.

The economists, using what they call the "inexorable laws of arithmetic and demographics", say that a crisis point will arrive in 2001 when Medicare becomes insolvent. The second will arrive in 2008 when the first of the Baby Boom generation begin to retire.

By 2012, if the current tax and spending policy is continued, Medicare, Medicaid, Social Security and federal employee retirement programs will consume all tax revenues collected by the federal government.

The ISU economists say these predictions could have an even greater impact for Iowans since we have an older population.

"National tax cut plans of both parties are politically popular but risk significant folly in the long run," say the economists.

Update on managed care developments

The American Medical Association makes available to the IMS weekly information on market trends in managed care. Following are items from recent releases.

• There was a 16% increase in the number of managed care plans during 1994, a 19% increase in the number of PPOs and a 9%

increase in managed care enrollment.

• Over 650 hospitals were involved in mergers or acquisitions in 1994. In 1993, the AHA recorded just 18 community hospital mergers.

• A California Medical Association study found for-profit HMOs spend more money on administration than not-for-profit HMOs.

• Employer-owned primary care centers may be the wave of the future. Delta Airlines, Bethlehem Steel, Goodyear, RJ Reynolds and John Deere have all built their own primary care clinics. John Deere has announced plans to develop a second John Deere Family Health plan center in the Des Moines metro area. The trend has been dubbed "backward integration".

• The number of employers using managed care plans to funnel injured employees to HMOs has increased to almost 50%, up from 20% in 1991.

• Some health systems — including Chicago's Rush Presbyterian — have established managed care colleges to educate primary care physicians on clinical practice guidelines, outcomes measurement and other key components of physician practice in a managed care environment.

• Risk management experts are concerned that, as providers consolidate, they are neglecting outpatient liability issues. St. Paul Fire and Marine reports that outpatient surgery claims jumped from \$5.1 million in 1992 to \$8.7 million in 1993.

• According to *US News and World Report*, an increasing number of physician specialists are retraining to become primary care physicians.

AMA capital source program

The *Wall Street Journal* and other major papers have carried stories describing the AMA's new Physicians Capital Source program, which Iowa physicians learned of during last October's Futures conference in Des Moines.

According to the *Wall Street Journal*, the

FINANCING PHYSICIAN VENTURES

In the May Iowa Medicine, Steve DeNelsky, senior financial consultant with Medical Alliances in Alexandria, Virginia, will discuss financing of physician managed care ventures — options available and steps necessary to obtain financing.

program "will give doctors business skills and introduce them to sources of capital so they can compete against insurers and investor-owned health maintenance organizations dominating the health care landscape."

Thomas Reardon, MD, AMA secretary-treasurer, said the program is "a way for physicians to preserve some of their autonomy by forming their own networks and establishing their own destiny."

For more information about the AMA Physicians Capital Source program, call 800/AMA-1066.

Reform may revive in congress

Portions of last year's health care bills, including insurance reform, were gaining support from Republican congressional leaders. Newt Gingrich held out the prospect of "building blocks" of reform going to President Clinton's desk as early as June if the president and Democrats don't try for anything sweeping.

Senate Republican leader Bob Dole supports a series of relatively limited market-

based reforms. These would include portability and protection for patients with pre-existing conditions.

In other developments in Congress, support appears to be growing for a complete transformation of the Medicaid program to give states much greater control of the system. Thomas Bliley, House Commerce Committee chairman, is calling for conversion of Medicaid into a system of block grants to the states.

In other developments:

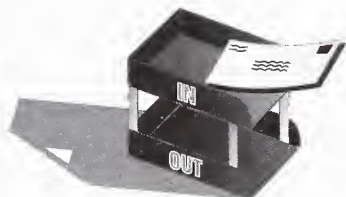
- The AMA asked Congress to work on a number of reforms, among them: changes in Medicare, insurance and tort reform, increased funding for medical education and research and cutting government red tape. Among possible Medicare changes — treating benefits for affluent Americans as taxable income and allow patients to opt out of Medicare and join private health plans.

- Republican leaders of the House Ways and Means Subcommittee on Health confirmed yesterday that affluent Medicare beneficiaries are an early target in the hunt for savings. **IM**

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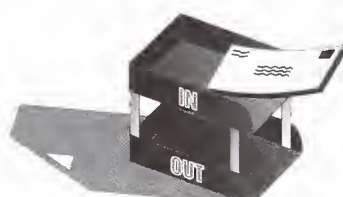
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Legislative Affairs

Bills in the Iowa Legislature

AT A GLANCE

The Iowa Medical Political Action Committee (IMPAC) will hold a reception on Friday evening, April 28, at 6 p.m. at the Marriott Hotel. The reception is planned in conjunction with the IMS Annual Meeting.

The American Medical Association legislative agenda for the 104th Congress includes the following major initiatives: medical savings accounts, regulatory relief/CLIA, professional liability reform, Medicare, the Patient Protection Act and antitrust relief.

The 1995 Governor's Conference on Aging will be held May 17 and 18 at University Park Holiday Inn in West Des Moines. The IMS is a cosponsor of the conference, entitled "Aging: Celebrating a Lifetime of Experience". For more information, contact the Iowa Dept. of Elder Affairs, 515/281-5187.

March 17 was the first legislative funnel deadline. By this date, most bills must have been approved by a committee in the house of origin. Several IMS priority issues met this deadline:

Statute of Limitations—HF 394

HF 394, reducing the extended statute of limitations for minors, has been approved by the House Economic Development Committee. There is considerable support in the House; the future of the bill is uncertain in the Senate. Contact with senators and representatives is urgently needed if this bill is to have a chance of passage. HF 394 reduces the statute of limitations for minors so that the normal statute of limitations begins running when a child reaches age six. This limit allows a lawsuit for an alleged birth injury to be filed until the child reaches age eight.

Statewide Trauma Plan—SF 118

The statewide trauma plan bill has passed the Senate and is in the House Human Resources Committee. SF 118, supported by the IMS, establishes a mechanism to coordinate trauma care through a trauma care designation system. Designations will be based on self-reported information. No hospital will be prevented from providing care for which it is licensed.

Physicians of various specialties and hospitals will be strongly represented on both the governing body and the quality assurance review committee. The plan was developed by the Iowa Trauma Systems Development Project Planning Consortium which was composed of physicians, hospitals, EMS providers, nurses and representatives of the Governor's Traffic Safety Bureau and the Iowa Department of Public Health.

Helmet Law—SF 224

SF 224 requiring motorcycle operators and passengers to wear protective helmets has

CONTACTING YOUR LEGISLATORS

Telephone numbers during the session:

Senators 515/281-3371
Representatives 515/281-3221
Governor 515/281-5211

Write to them at:

STATEHOUSE
Des Moines, Iowa 50319

You may also contact your legislators at home when the legislature is not in session. If you don't know who your legislator is or need your legislator's home address and phone number, call Lyn Durante of the IMS staff, 800/747-3070 or 515/223-1401.

been approved by the Human Resources Committee. The IMS supports this bill and encourages physicians to ask both Senators and Representatives to vote for it. Support.

Tobacco—SF 203

The IMS/Tobacco Free Coalition bill has been approved by the Senate Human Resources Committee. It would require restaurants with smoking areas to eliminate transmission of tobacco smoke into non-smoking areas, repeals the prohibition on local governments enacting tobacco ordinances which are stricter than state law, and provides that the Department of Public Health would be responsible for adopting regulations to enforce the clean indoor air act. Support.

Uniform Anatomical Gift Act—SF 117

SF 117, updating the state's Uniform Anatomical Gift Act, has been passed by the Senate and approved by the House Human Resources with some minor modifications. Current law was passed in 1983; SF 117 modernizes the act and makes such changes as allowing teenagers to sign organ donor cards with the cosignature of a parent and provides

IMS/AMA POLICY ON CAPITAL PUNISHMENT

A bill to reinstate capital punishment went down to defeat in the Iowa Legislature. However, it is possible the issue could be raised again at a later date. For future reference, following is a summary of IMS/AMA policy.

The AMA says a physician's opinion on capital punishment is "the personal moral decision of the individual", but that it is unethical for a physician to participate in legally authorized executions.

In its policy compendium updated last June, the AMA says "a physician, a member of a profession dedicated to preserving life when there is hope of doing so, should not be a participant in a state execution."

Physician participation is clearly defined as an action which would directly cause the death of the condemned; or an action which would assist, supervise or contribute to the ability of another individual to directly cause the death of the condemned.

According to the AMA's guidelines, physicians should not monitor vital signs either on site or remotely, attend or observe an execution as a physician or render technical advice regarding execution.

During the course of the 1995 legislature, IMS representatives monitored capital punishment proposals to ensure that physician participation was not mandated.

Managed Care

The IMS is continuing to negotiate with third party payers to voluntarily include provisions of the AMA's Patient Protection Act in their managed care plans.

Negotiations are focusing on providing regular opportunities for all physicians to apply to a plan, letting physicians know the criteria for selection and due process in the case of rejection or termination from the plan. Several meetings have been held with payer representatives.

Any Willing Provider

Several different any willing provider bills have been introduced at the request of optometrists and chiropractors. HSB 233 requires health care plans with limited provider networks to allow direct access to providers who "utilize differential diagnosis and physical examinations to determine human ailments". Access to specialist physicians may be limited. The IMS opposes these bills.

PA Rules

A new draft of administrative rules has been proposed by the Board of Physician Assistant Examiners relating to practice and supervision requirements. The IMS is reviewing the draft. The IMS was very concerned about the previous version of the rules because it significantly reduced requirements for supervision and experience for PAs who practice in remote clinics without a physician on site.

Legislative Schedule

April 7: Final date for Senate bills to be reported out of House committees and House bills out of Senate committees. (Certain bills are exempt.)

April 17: Only unfinished business, conference committee reports and exempt bills may be considered.

April 28: 110th day of session. Adjournment likely within a week. **IM**

recognition of intent to donate indicated on a drivers license. The IMS supports this bill.

Prior Authorization for Prescription Drugs

The Department of Human Services has recommended that prior authorization be required for use of any brand-name prescription drug for which a generic equivalent is available. To receive authorization for the brand name, documentation of treatment failure with the generic would be required. The proposal is a cost cutting measure.

Physicians already widely use generics for Medicaid patients (67% of the time when a generic is available). The IMS supports the use of generic drugs if the treating physician determines it is appropriate for the patient.

In place of the prior authorization requirement, IMS recommends the Medicaid program — through the Drug Utilization Review Commission — focus on providing education and information to physicians about the availability and appropriate use of generic drugs.

Medical Economics

AT A GLANCE

A recent story in the Boston Globe said the number of residency programs teaching how to perform abortions is dropping. In 1975, 26.3% of all programs routinely offered training in first trimester abortions. By 1991, the figure had dropped by more than one half.

As much as 97% of non-insulin diabetes, up to 70% of heart disease, 11% of breast cancer and 10% of colon cancer in overweight Americans can be attributed to excess weight, according to C. Everett Koop, former surgeon general. Obesity is a "serious disease" that contributes to more than 300,000 deaths per year, he says.

Medicare B claims system change

On April 1, Blue Cross and Blue Shield, Iowa's Medicare carrier, changed to a claims processing system called Multi-Carrier System (MCS). The system does not change Medicare rules or reimbursement. Physicians should continue to report services as they have in the past.

The system will not affect processing of electronic or paper claims (80% of claims are electronic); physicians are asked to submit claims as usual.

(However, according to the Medicare carrier, psychiatrists will find that the Provider Remittance Advice does not show the psychiatric deduction.)

The most obvious change will be a completely different provider remittance notice. During these initial weeks of transition, please watch your claims payments and report incorrect payments to the Medicare carrier immediately.

A special *Medicare Info* was sent to all providers in mid-March containing complete details on the transition to the new system.

If you experience problems with the new system, please contact Medicare at the usual numbers or Mary Reinsmoen at the IMS, 800/747-3070.

Antitrust predictions

Antitrust relief for physicians who wish to compete in the new marketplace is a top priority of the American Medical Association, but some experts predict that physicians can expect no changes in antitrust rules.

The AMA argues that physicians need more leverage to bargain with hospitals and HMOs and to make it easier for doctors to bargain together and set up their own networks.

However, according to the *Kiplinger Newsletter*, antitrust relief is "staunchly opposed" by hospitals, HMOs and nurses.

CHMIS activities update

The Community Health Management Information System (CHMIS) Governing Board is continuing to meet monthly to work out policy and procedural issues to implement Phase I of CIIMIS in Iowa.

On July 1, 1996, all health care providers must submit claims electronically using a standard claim format; all payors will be required to accept the standard format. Many details regarding how the CIIMIS will work have yet to be determined by the Governing Board and five advisory committees.

The IMS has at least one member physician on each of these five advisory committees and two on the Governing Board.

As of press time, the main agenda item for the Governing Board was the financing of the CIIMIS. Also, the Data Advisory Committee had completed a recommended list of data elements which could be collected from the HCFA-1500 and UB-92 forms for the CIIMIS data base. This list of data elements will now go to the CIIMIS Governing Board for approval.

The Ethics and Confidentiality Advisory Committee is formulating recommendations on who will have access to data collected through the CIIMIS and is reportedly taking a conservative approach regarding "qualified users".

The Technical Advisory Committee is working to develop criteria to certify CHMIS networks in Iowa. They will also work with a consultant to develop the request for proposal (RFP) for the repository contract.

The Iowa Medical Society's CHMIS Committee planned to meet early this month to finalize recommendations on IMS CHMIS policy. The committee will send a supplemental report to the House of Delegates at the end of this month. This report will include a proposal for a comprehensive IMS CHMIS policy. This policy will represent the IMS position and will guide physician and staff efforts throughout the creation and implementation of CIIMIS.

Current IMS CHIMIS policy, approved by the IMS Executive Council in 1993, says the IMS favors electronic billing through a CHIMIS but opposes creation of a central repository to collect and disseminate information from patients' medical records.

According to the IMS position statement, the CHIMIS as proposed, "has the potential to reduce administrative costs, increase the efficiency of claims submission and payment and collect needed information on health care costs, utilization and quality. The IMS supports collection, analysis and dissemination of data on health care charges, utilization and quality using information from the insurance claim form."

IMS staff are available to give a special program on CHIMIS to any group of member physicians. To schedule a program, call Barb Heek, 515/223-1401 or 800/747-3070.

Vaccine for Children program

The Iowa Department of Public Health (DPIH) is ready to begin enrollment of

providers in the Vaccines for Children (VFC) program. Implementation of the program is anticipated June 1, 1995.

This program will replace the current Medicaid Vaccine Replacement Program. The Vaccine Replacement Program will be phased out in the months following implementation of the VFC program.

The VFC program was scheduled to begin October 1, 1994 for public and private sector providers. Disbandment of the national Vaccine Distribution Center forced the delay of the private sector implementation.

The DPIH is currently seeking bids from pharmaceutical distributors for private sector providers. Implementation of the program is provisional providing a pharmaceutical distributor is selected.

Physicians will be receiving information on the VFC program from the DPIH and are encouraged to enroll as soon as possible to allow for processing and delivery of vaccines during the month of June. For more information, call Don Callaghan at 515/281-7301 or Becky Roorda at the IMS, 800/747-3070. **IM**

In the 1994 elections, IMPAC contributed over \$66,000 to 114 candidates running for state office. IMPAC contributed to 105 winners for a 92% success rate. Obviously, contributions from Iowa physicians were well spent.

But we cannot stop there. The 1996 elections are just around the corner. We cannot afford to let the interest of medicine be overshadowed by the banter of political rhetoric. The strides

made by IMPAC in 1994 must be sustained through 1996 if Iowa physicians are to be heard by their lawmakers.

If doctors abdicate responsibility to participate in the political process, it is certain that non-physician groups will take our place. They have already begun their fund-raising and grass roots work for 1996 and we cannot afford to fall behind now.

The time has come to step forward and be heard through a strong IMPAC.

Join IMPAC today!



**Here's where
the real
battles are
being
fought**

Practice Management

AT A GLANCE

Medicare changed to a claims processing system called MCS (Multi-Carrier System) on April 1. The system does not change Medicare rules, but there will be a completely different provider remittance notice. For additional details, see this month's Medical Economics section.

On July 1, 1996, all Iowa physicians will be required to submit claims electronically through the CHMIS system and all payers will be required to accept a standard electronic format. If you want to know more about CHMIS and what it means for Iowa physicians' offices, call Dean Gillaspey or Barbara Heck at IMS headquarters, 515/223-1401 or 800/747-3070.

Coding extravaganza this month

If you want answers to tough questions on CPT, ICD-9 and HCPCS coding, the Iowa Medical Society and IMS Services can help. On Tuesday, Wednesday and Thursday, April 18, 19 and 20, there will be a coding extravaganza at the Best Western Des Moines International.

Nationally known coding expert Nancy Maguire will teach the seminars. There will be seminars on pediatric coding, surgical coding, primary care coding, orthopedic surgery, neurosurgery and ENT coding.

If you want to come to the seminar and would like to stay overnight, a block of rooms has been reserved at a special rate of \$52 per night. For reservations, call the hotel directly at 515/287-6464.

For more information or to register, call Mary Reinsmoen at IMS Services, 800/728-5398.

Tuberculosis procedures

Does your office have a written policy pertaining to employees or patients with tuberculosis? Can your staff spot symptoms of TB?

TB is a growing problem. There have been three cases of known exposure in Iowa since December. The Center for Disease Control (CDC) released final guidelines on infection control. Although TB is now covered under the OSHA general duty clause, there is a proposal for TB standards in OSHA.

Physician offices are advised to start thinking about a policy when this proposal becomes law. The IMS Office Safety and Compliance seminar (see box below for details) will cover this and many other safety issues. An OSHA industrial hygienist will present OSHA regulations at this seminar, scheduled for several sites around Iowa.

Retirement readiness

The Iowa Medical Society will sponsor a workshop on retirement readiness in three locations in Iowa during May.

The workshops will be taught by Jerry Foster, president of Retirement Advisors, Inc. The seminar, designed for physicians and their spouses, answers important questions for physicians preparing for retirement:

- How much is enough?
- Can I retire at my target age?
- Can I outlive my resources?
- How can I control taxes?
- Will I be emotionally ready to retire?

The cost of the seminar is \$125 for members (\$150 for a member couple); \$175 for a non-member (\$200 for a non-member couple). All prices include lunch.

The retirement seminars are planned for Wednesday, May 10 in Cedar Rapids; Wednesday, May 17 in Davenport; and Wednesday, May 24 in West Des Moines. For more details on upcoming seminars, check the insert in this month's *Iowa Medicine*. **IM**

UPCOMING IMS SERVICES SEMINARS FOR YOU

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specialties**

*Office Safety/Compliance

**Wednesday, May 10, Iowa City
Thursday, May 11, Lake City
Wednesday, May 17, Marshalltown
Thursday, May 18, Burlington
Wednesday, May 24, Dubuque
Wednesday, May 31, Council Bluffs**

*Anatomy and Physiology

Tuesday, May 9, Cedar Rapids

*These seminars are part of the IMS Medical Business Specialist (MBS) certificate program

For more information on any seminar, call Mary Reinsmoen or Sherry Johnson at the IMS, 515/223-1401 or 800/728-5398.

MIDWEST MEDICAL INSURANCE COMPANY FOCUS ON RISK MANAGEMENT

Medication errors

Prescription of medication. It's one of the most common procedures performed in the physician's office. A recent study of malpractice claims reveals that medication error claims are one of the most common and expensive areas of malpractice losses.

The study by the Physician Insurers Association of America emphasizes that medication errors can cause significant patient injuries and that many of these injuries and medication-related malpractice claims can be avoided by using these risk management steps:

- Chart all prescriptions and refills on a medication flowsheet.
- Obtain and document medication histories and update them as necessary.
- Inquire about and document allergies in a

consistent and conspicuous location.

- Read the medical record for contraindications to medications, excessive number of refills and allergies.

- Educate patients about their medications.

- Obtain and document informed consent for prescription medications with potentially significant drug complications and side effects.

- Monitor drug usage, particularly with controlled substances.

For further information, contact Lori Atkinson, MMIC risk management coordinator, MMIC West Des Moines office, PO Box 65790, West Des Moines, 50265, 800/798-9870 or 515/223-1482.

NEW START DATE FOR MANAGEMENT EDUCATION PROGRAM

Sponsored by the Iowa Medical Society & Iowa Medical Group Management Association

The start date for the next MEP has been changed to **May 19-20, 1995.**

This allows more time for those people who need to adjust their schedules and obtain approval for tuition.

Registration deadline is April 24, 1995.

Response to the MEP has been good, including registrations from Des Moines, Waverly, Kalona, Iowa City, Atlantic, Boone, Dubuque and Fort Dodge. All classes are held at IMS headquarters in West Des Moines. ***This 12-month program is held one weekend a month from 1:00-6:00 p.m. on Friday and from 8:00 a.m.-1:00 p.m. Saturday.***

If you've been avoiding the time and financial commitment of enrolling in an MBA program, please give consideration to joining this MEP, a mini MBA program. Dr. James White, IMS president, says physicians' roles are changing. ***"Today, physicians have to be more than clinicians. Physicians must also be managers."*** Alice Eveleth, president of IMGMA, says clinic administrators ***"must be knowledgeable in a wide variety of management leadership topics. Today, more than ever, survival depends upon physicians and administrators working as partners."***

The MEP introduces physicians and administrators to the business and management knowledge they need to succeed as leaders and managers in today's health care environment. The program improves communication and teamwork between administrators and physicians to facilitate better integration of administration and clinical decision-making.

For more information, including a schedule, call Mary Reinsmoen at the Iowa Medical Society, 800/728-5398 or 515/223-1401.

Newsmakers

AT A GLANCE

Dr. John Eckstein has been selected by the Secretary of Veterans Affairs as a VA Distinguished Physician. Dr. Eckstein, who served over 20 years as Dean at the UI College of Medicine, joins 11 other physicians in this prestigious program. During his three-year appointment, he will serve as consultant to VA leaders and advisory boards across the nation.

Dr. Laverne Wintermeyer, Iowa state epidemiologist, has retired after 18 years with the Iowa Department of Public Health. The new state epidemiologist is Dr. M. Patricia Quinlisk, formerly of Oklahoma.

Dubuque's Finley Hospital has been selected as one of the 100 Top Hospitals—Benchmarks for Success Honorable Mention Award Winners in a research report from Health Care Investment Analysts, Inc., a Baltimore-based research company and Mercer Management Consulting, Inc., New York.

Awards, appointments, etc.

Dr. Michael Jones, UI College of Medicine associate professor of preventive medicine and environmental health, was appointed International Biometrics Society representative to the American Association for the Advancement of Science for the Eastern North American Region. **Dr. Susan Johnson**, UI associate professor of obstetrics and gynecology, has been appointed by the National Board of Medical Examiners as a member of the U.S. Medical Licensing Examination (USMLE) Step 2 Test Material Development Committee. The USMLE, a joint program of the Federation of State Medical Boards and the National Board of Medical Examiners, provides a common evaluation system for all medical license applicants in the U. S. **Dr. Madeline Shea**, UI assistant professor of biochemistry, has been elected to a four-year term on the council of the Biophysical Society. Researchers at the UI have received a grant from the Centers for Disease Control and Prevention to investigate the health status of Iowans who served in the Persian Gulf War. **Dr. David Schwartz**, associate professor of internal medicine, heads up the research team. **Dr. Gary Koretzky**, UI associate professor of physiology and biophysics and internal medicine, was appointed to the Kelting Chair in Internal Medicine, which supports the work of a faculty member involved in arthritis research. Dr. Koretzky also received the 1994 Young Investigator Award from the Midwest Region of the American Federation for Clinical Research at the Federation's annual meeting in Chicago. **Dr. Douglas LaBrecque**, UI professor of internal medicine, was appointed treasurer for the World Congresses of Gastroenterology. **Dr. Robert Woolson**, UI professor of preventive medicine and environmental health, has been elected to a three-year term on the board of directors for the Society of Clinical Trials, which has about 2500 members interested in the development of scientific methods for the design, analysis and operations of controlled

clinical trials. **Dr. Michael Pfaller**, UI professor of pathology, has been appointed to the editorial board of *Clinical Infectious Diseases*. **Dr. Richard Nelson**, UI professor of pediatrics, has been appointed executive associate dean. **Dr. Thomas Weingest**, UI professor and head of ophthalmology, was re-elected to a three-year term as senior secretary for Clinical Education of the American Academy of Ophthalmology. **Dr. Randy Kardon**, UI associate professor of ophthalmology, has received a five-year career development award from the Veterans Administration to support research in the neurophysiology of the pupil of the eye. He was one of seven physicians in the nation to receive the award. **Dr. Edwin Stone**, UI associate professor of ophthalmology, received a \$55,000 award from the Grousebeck Foundation for studies on Leber's optic neuropathy, a hereditary disorder which often leads to blindness in young men aged 10 to 21. **Dr. Wallace Alward**, UI associate professor of ophthalmology, received a \$15,000 unrestricted research grant from the Glaucoma Foundation to pursue studies dealing with the diagnosis and treatment of glaucoma. **Dr. Peter Densen**, UI professor of internal medicine, has been appointed associate dean for student affairs and curriculum. Dr. Densen has served in this position on an acting basis since 1992. **Dr. Edmund Franken, Jr.**, UI professor of radiology, has been named the first Roentgen Centennial Fellow in Radiologic Innovation by the Radiology Society of North America. Dr. Franken will receive up to \$100,000 for teleradiology research.

New members

Newton

Lafayette Twyner, MD, family practice

Orange City

Steven Locker, MD, general surgery

Ottumwa

Herbert Macalalad, MD, internal medicine

Office Safety and Compliance Issues★

This half-day class reviews suggested and required safety programs for physician offices. Workers' Compensation, OSHA, ADA and general office safety are included. Seminar time is 1:00 p.m. to 4:30 p.m. COST: \$85 for IMS member or staff; \$140 for non-member or staff. Representatives from the Iowa OSHA and the Iowa Farm Bureau will join Mary Reinsmoen of the IMS staff in presenting this program.

DATE	CITY	SITE
Wed 5/10	Iowa City	Mercy Hospital Medical Plaza, Scanlon Room
Thu 5/11	Lake City	Stewart Memorial Hospital, Conference Center
Wed 5/17	Marshalltown	Marshalltown Medical & Surgical Center, Room A
Thu 5/18	Burlington	Burlington Medical Center, Room 4
Wed 5/24	Dubuque	Finley Hospital, Auditorium
Wed 5/31	Council Bluffs	Jennie Edmundson Memorial Hospital, Auditorium

Anatomy and Physiology★

This full-day introductory class provides a basic understanding of anatomical structure and function. The major systems of the human body are covered in this practical course and a text is included. Seminar time is 9:00 a.m. to 4:00 p.m. COST: \$150 for IMS member or staff (includes lunch); \$240 for non-member or staff (includes lunch). Instructor: Craig A. Canby, Ph.D., Assistant Professor of Anatomy at the University of Osteopathic Medicine and Health Sciences in Des Moines, Iowa.

DATE	CITY	SITE
Tue 5/9	Cedar Rapids	St Luke's Hospital Resource Center Formal Lounge

Retirement Readiness

This workshop-format class is designed especially for physicians and spouses to attend as a couple. Topics include how much it will cost to retire, how to save for retirement and how to invest retirement funds. A personal financial planning conference can be arranged following the workshop. The presenter is Jerry Foster, president of Retirement Advisors, Inc., West Des Moines. The seminar time is 10:00 a.m. to 3:30 p.m. in all locations. COST: \$125 for IMS members (\$150 for member couple); \$175 for non-member (\$200 for non-member couple). All prices include lunch.

DATE	CITY	SITE
Wed 5/10	Cedar Rapids	St. Luke's Medical Office Plaza, Room 2
Wed 5/17	Davenport	Genesis East, Interconnect Lounge
Wed 5/24	West Des Moines	IMS Headquarters, Bierring Room

★ These programs are part of the IMS Medical Business Specialists (MBS) Certificate Program.

Registration Form

Office Safety _____ Anatomy & Physiology _____ Retirement Planning _____

Name(s): _____

Clinic/Practice Name: _____

Address: _____

Phone: _____ Fax: _____

Amount Enclosed: _____ Date and Location: _____

Please make checks payable to IMS SERVICES. Mail check and registration form to:
IMS SERVICES ATTN: Sherry Johnson, 1001 Grand Avenue, West Des Moines, IA 50265-3599.

Kent Walker, MD, dermatology

Pella

Lec Henry, DO, diagnostic radiology
Craig Wittenberg, MD, family practice

Perry

Jeffrey Allyn, MD, family practice
William Durbin, MD, family practice
Kurt Klise, MD, family practice
Steven Sohn, MD, family practice

Sheldon

William Jongewaard, MD, general surgery

Sioux City

David Erlbacher, MD, resident
Allan Fischer, DO, internal medicine
Gary Hattan, MD, resident
Christopher Hughes, MD, neurology
Alan Kessler, DO, resident
James Lauck, Jr., MD, family practice
Jerome McFadden, DO, resident
Kelly Moser, MD, resident
Mary Ryken, MD, psychiatry
David Wagner, MD, otolaryngology

Tipton

Kamala Cotta, MD, internal medicine
Karyn Shanks, MD, internal medicine

Waterloo

Tom Baccam, DO, resident
John Holley, MD, resident
Thomas Mitchell, MD, resident
Steve Olsen, DO, resident
Malati Pamulapati, MD, resident
Robin Plattenberger-Gilmore, DO, resident

Waverly

Daniel Darnold, MD, family practice

Webster City

Wayne Ventling, II, DO, diagnostic radiology

West Des Moines

Lynn Nelson, MD, orthopaedic surgery
Sally Jo Studer, DO, family practice

Deceased member

Frank Richmond, MD, 101, life member, family practice, Fort Madison, died October 1 

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GENESIS REGIONAL HEART CENTER

CARDIOLOGY AT THE BIX

Friday, July 28, 1995
Jumer's Castle Lodge
Bettendorf, Iowa

FACULTY



WILLIAM W. PARMLEY, M.D.
Professor of Medicine, USFC; Chief
of Cardiology, Moffitt/Long Hospital,
San Francisco, California.



FREDRICK (FRITZ) HAGERMAN, Ph.D.
Professor of Biological Sciences,
Ohio University, Athens, Ohio.



PAUL H. KRAMER, M.D.
Medical Director, Cardiovascular
Laboratories, Mid America Heart
Institute of St. Luke's Hospital,
Kansas City, Missouri.



MARJORIE TROLLER HAGERMAN
MS, RD, LD, Chair, Foods & Nutrition
and Director, Didactic Program
in Dietetics, Ohio University, Athens, Ohio.



ARTHUR MOSS, M.D.
Professor of Medicine, University
of Rochester Medical Center,
Rochester, New York.



NANETTE KASS WENGER, M.D.
F.A.C.C., Professor of Medicine (Cardiology)
Emory University School
of Medicine, Atlanta, Georgia.

JAMES McCLELLAND, M.D.

Assistant Professor, University of Oklahoma Health Sciences Center, Oklahoma City, Oklahoma.

PUTTIN' ON THE BIX: MUSIC AND MEDICINE

Now in its fifth year, Cardiology at the Bix, sponsored by Genesis Regional Heart Center features internationally acclaimed speakers, as well as attendees from all over the country. Held at the beautiful Jumer's Castle Lodge in Bettendorf, it draws internationally acclaimed physicians.

Attendees can also enjoy the Bix Beiderbecke Memorial Jazz Festival, which features top-notch bands from around the world and honors Davenport native son and jazz great Bix Beiderbecke.

More than 20,000 runners are expected for what Runner's World calls "the road race with the most community spirit." Scheduled for July 29, the Bix 7 is the eighth largest road race in the United States.

REGISTRATION INFORMATION:

Registration Fee: \$95 Physician \$55 Nurse/Allied Health Professional
Fee includes attendance at the symposium, a ticket to the 'Friends of Bix' Cocktail Party, and a complimentary dinner aboard the Casino Rock Island.

Registration deadline is July 3, 1995. Confirmation and entertainment details will be sent upon registration.

For further information, please contact Anne Pauly (319) 383-1062.



**GENESIS
MEDICAL CENTER**

Genesis Regional Heart Center
1227 East Rusholme Street
Davenport, Iowa 52803

UI College of Medicine in the 21st century



The University of Iowa College of Medicine is well on its way into the 21st century and I'm proud to be able to serve in a leadership role for this well-respected medical college.

The leadership challenges we face as part of an academic health sciences center will be to manage change together to provide the highest quality health care at the lowest possible cost with the greatest efficiency; provide outstanding education and training to our students—the future health care professionals of Iowa and the world; and foster the best environment for research that pushes forward the frontiers of science.

As is the case with most academic health sciences centers, the University of Iowa College of Medicine faces challenges from the market-driven changes in health care delivery. We're having to reinvent our centers to have access to future streams of clinical income—which can account for as much as 40% of a medical college's funds. Only then can we continue to fulfill our education, research and clinical service missions to the people of Iowa.

Above all, we must meet society's needs, especially in providing more generalist physicians. We must also meet Iowa's needs for health care and services to rural areas.

Renewal time for medical curriculum

As a strong supporter of educational innovation, I was inspired when our faculty recently

gave the green light to the Medical Education Committee to proceed with revamping the curriculum. Through these changes in structure and content and other unique features in what we call the "generalist curriculum," the education we provide will be responsive to the environment and advances in medical knowledge.

On another educational front, the College continues to contribute to the quality of health care by providing extensive continuing education opportunities for physicians and other health professionals. In 1994, the College sponsored more than 200 conferences and workshops and instituted a new competitive grant program for faculty to develop community-based education programs that utilize the Iowa Communications Network (ICN). The College

We must meet Iowa's needs for health care and services to rural areas.

sponsored its first continuing education course via the ICN in March.

Managing change through interdisciplinary research

In the spirit of fostering interdisciplinary research that's more discipline-oriented, the UI Cancer Center won an interdisciplinary planning grant stimulating further joining and collaboration of the varying cancer research interests across campus.

We believe the University of Iowa can become a national leader with a cancer center focusing on the special needs of rural populations. We're working to seek formal designation of the center by the National Cancer Institute. This and like initiatives are becoming more important to ensure high quality research and



ROBERT KELCH, MD
Dean, University of Iowa
College of Medicine

Dr. Kelch, a pediatric endocrinologist, assumed the deanship of the UI College of Medicine in August 1994 after more than 20 years on the faculty of the University of Michigan.

Dean's Message

continued

cost effectiveness. Our Cancer Center and its interdisciplinary push is one example of other programmatic developments we'll see in the near future.


Financing educational programs

As crucial as these programs are, questions always arise about how we're going to finance them and meet society's needs. As we move our clinical teaching to ambulatory settings, the cost of medical education will increase strikingly. We can't and won't ask our students to bear the full burden of these increasing costs. We believe it's better to involve and seek assistance from community providers. They can assist in the teaching process, and perhaps more indirectly, bring an awareness to society as a whole that supporting education is worthwhile especially as we attempt to better meet the primary health care needs of Iowans.

Producing health professionals

A serious look at the production of health care professionals, including the cost of their training and quantity produced, is probably warranted.

While we're probably not overproducing generalist physicians, we do have a distribution problem. We believe the more our students and faculty get out in the communities and participate in education and training sessions, we'll likely facilitate recruitment and retention of physicians in those areas. Getting residents into underserved areas for training is also important. Studies have shown that the regional location of a physician's graduate training program is a key determinant of his or her practice location.

I'm proud to join you and be part of the rich tradition of collegiate involvement that we have with the Iowa Medical Society. 

While we're not overproducing generalist physicians, we do have a distribution problem.

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Ask for Cindy Walker

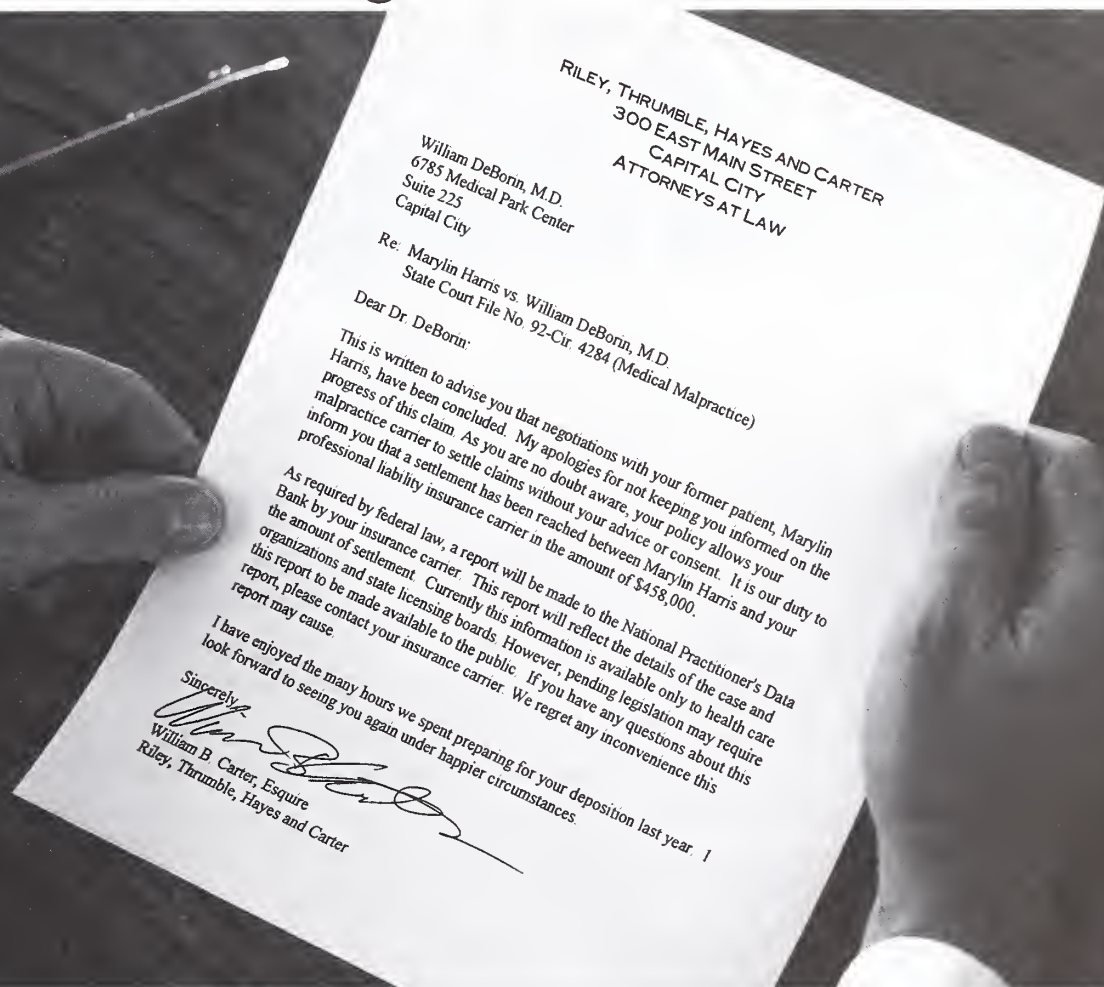
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William DeBorin, M.D.
6785 Medical Park Center
Suite 225
Capital City

Re. Marilyn Harris vs. William DeBorin, M.D.
State Court File No. 92-Cir. 4284 (Medical Malpractice)

Dear Dr. DeBorin:

This is written to advise you that negotiations with your former patient, Marilyn Harris, have been concluded. My apologies for not keeping you informed on the progress of this claim. As you are no doubt aware, your policy allows your malpractice carrier to settle claims without your advice or consent. It is our duty to inform you that a settlement has been reached between Marilyn Harris and your professional liability insurance carrier in the amount of \$458,000.

As required by federal law, a report will be made to the National Practitioner's Data Bank by your insurance carrier. This report will reflect the details of the case and the amount of settlement. Currently this information is available only to health care organizations and state licensing boards. However, pending legislation may require this report to be made available to the public. If you have any questions about this report, please contact your insurance carrier. We regret any inconvenience this report may cause.

I have enjoyed the many hours we spent preparing for your deposition last year. I look forward to seeing you again under happier circumstances.

Sincerely,

William B. Carter, Esquire
Riley, Thumble, Hayes and Carter

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A new course for *Medical* Education



When first-year medical students arrive at the University of Iowa College of Medicine this coming fall, they will begin the educational journey to a medical career along a new path — a revamped undergraduate medical curriculum.

Prompted by the exponential growth in medical knowledge, the increasing significance of teaching in ambulatory care settings and the impact of managed health care on medical practice, the University of Iowa College of Medicine initiated a detailed study of its curriculum in the fall of 1991.

The findings of this review were distributed widely in 1993 and served as the starting point for proposed modifications in the structure, content, setting and pedagogical processes of medical education at the UI.

On November 14, 1994, College of Medicine faculty voted overwhelmingly in support of proceeding with detailed development and implementation of these changes, the first phase to begin with the class entering this fall.

Major changes in emphasis

Major changes in emphasis include earlier patient exposure, increased integration and clinical relevance in the basic science courses and community-based primary care in the clinical years. Structural revisions include

limiting contact hours to 24 hours a week in the preclinical years and increasing the weeks of required course work in the senior year while retaining 20 weeks of elective time.

Curriculum management is also being restructured, with increased responsibility allocated to six curriculum directors: one for each of the first four semesters, one to oversee the clinical years and another for a new three-semester course entitled "The Foundations of Clinical Practice". These directors will be charged with assuring integration of material among courses in a semester and between semesters, as well as assuring clinical relevance of course content.

Earlier exposure to patients

As currently envisioned, the first year will

Major changes in emphasis include community-based primary care in the clinical years.

begin with semester-long courses in gross anatomy and biochemistry. A 10-week molecular and cellular biology course will give way to a course in medical genetics that runs through the remainder of the semester. The spring semester consists of a core



PETER DENSEN, MD
Dr. Densen is associate dean for student affairs and curriculum at the University of Iowa College of Medicine.



course that seeks to integrate functional anatomy, histology, embryology and physiology from an organ system approach.

A greatly revised course in neuroscience will run parallel with this integrated systems core. Running concurrently with the basic science courses, the new course, "The Foundations of Clinical Practice", will give students their first exposure to patients, disciplines such as preventive medicine and critical appraisal skills.

Major goals for this course include developing the interpersonal skills critical for patient interactions and facilitating students' transition to an adult style of learning.

A new course, "The Foundations of Clinical Practice", will give students their first exposure to patients.

Six clerkships complete by third year

All six of the generalist core clerkships must be completed by the end of the third year. This way the basic skills just acquired in the second-year introduction to clinical medicine course will receive appropriate early reinforcement.

A six-week community-based primary care rotation will serve to further acquaint students with the settings in which generalist physicians practice medicine.

Successfully implementing this generalist curricular component will depend on the development of extramural educational campuses and will require the cooperation and collaboration of many physicians throughout Iowa. The College of Medicine welcomes the opportunity to collaborate with all Iowa physicians in this important endeavor. **IM**



Beyond measles and influenza:

The future of vaccines

The usefulness of antibiotics has become more limited due to the growing ability of bacteria to become resistant. The preventive potential of vaccines may offer solutions to some of today's medical challenges, say UI experts.

Long before Edward Jenner's landmark experiments opened the way for the development of the smallpox vaccine, ancient Chinese physicians practiced inoculation for the disease. Today's medical scientists, armed with the advanced tools of molecular biology and genetic analysis, are still searching for ways to guard against the microorganisms that ail us. What they're finding may offer new protection against disease and improve the way vaccines are delivered, adding to the variety of vaccines that have become public health staples.

Researchers throughout the University of Iowa College of Medicine are exploring bacteria and viruses ranging from *Pseudomonas* and *Gonococcus* to papillomavirus. They are looking for the mechanisms these culprits use to infect humans. Knowledge about how these microbes operate could help investigators design ways to interfere with those mechanisms and ultimately develop strategies for vaccines.

"There are tremendous opportunities for new vaccines," says Dr. Michael Apicella, UI

professor and head of microbiology. "In the future, physicians will be armed with a wider array of vaccines that may be delivered in very novel ways.

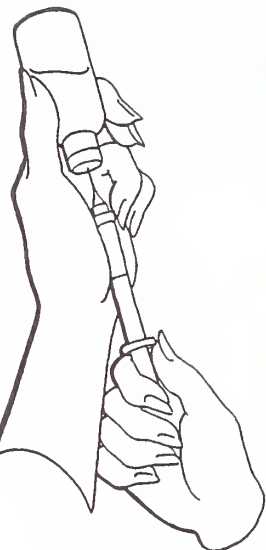
"Before the 1950s, only killed vaccines of whole organisms were available," Apicella says. "Now we are finding components of bacteria that can be modified, or attenuated, for use in vaccines." For example, the 'old' pertussis vaccine had many side effects, some quite serious. Scientists have modified the vaccine, eliminating its toxic component.

The new and the improved

Some vaccines may be closer at hand than others. Apicella predicts that the next major victory will be improved vaccines for pneumococcal pneumonia, a major cause of death among the elderly and in developing countries.

A vaccine for middle ear disease — a source of woe for many young children — may also be around the corner. Dr. Apicella has patented one, based on a protein in the cell wall of the *haemophilus* bacteria, which is

In the future, physicians will be armed with a wider array of vaccines delivered in very novel ways.



VERA DORDICK

Ms. Dordick is assistant director of Health Science Relations at the University of Iowa College of Medicine.

currently in the first phase of clinical trials.

“Pneumococcal bacteria can also cause middle ear diseases, and the proteins in its cell wall might also be useful,” says Dr. Apicella.

Efficacy of TB vaccine varies

For other diseases, like tuberculosis, existing live vaccines provide limited protection.

“The current tuberculosis vaccine has varied widely in efficacy, doesn’t allow for TB skin testing and is probably not as effective for pulmonary TB, the most common type,” says Dr. Larry Schlesinger, UI assistant professor of internal medicine. “The resurgence of TB during the past decade and the rising number of antibiotic-resistant strains of TB have heightened interest in preventing the disease.”

Schlesinger’s laboratory team is trying to identify the major molecules on the TB bacterium that allow it to enter specialized white blood cells called macrophages. These cells serve as the normal host niche for the bacterium.

“Our long range goal is to determine whether vaccinating people with the bacterial molecules will create immune responses that block the bacterium from entering macrophages. We want to find a way to interrupt the life cycle of the organism,” he explains.

“We’re also working to create molecules for specifically identifying and destroying the white cells that carry bacteria. This will serve as a form of targeted immunotherapy that is similar to cancer treatment approaches.

Hope for fighting viruses, parasites

Developing vaccine strategies for viruses presents different challenges, however. The human papillomavirus (HPV), the most common viral sexually transmitted disease today, lives in human cells and uses their machinery to replicate and maintain its life cycle, says Dr. Patricia Winokur, UI assistant professor of internal medicine. Prevention strategies are key, because therapies for genital warts are inefficient and don’t prevent recurrence, she adds.

“It’s difficult to interfere with HPV and leave the surrounding tissues unharmed. We know that two viral proteins interact with each other and with the host cell. These two proteins could provide important targets for new antiviral therapies,” she explains. “A vaccine for HPV is far in the future.”

Vaccines for parasitic diseases have proven just as elusive. While not common in the U.S., leishmaniasis, spread through the bite of the sandfly, is a major problem in many areas of the world. The fatal visceral form of the disease is epidemic in Sudan, Brazil and India.

“Current treatments for Leishmania have toxic side effects. A vaccine would be extremely useful, particularly for developing countries where access to medical care is limited,” says Dr. Mary Wilson, UI associate professor of internal medicine.

Wilson is examining parasite proteins that might be useful in developing a vaccine, particularly if they are given with another organism that might enhance the immune

Therapies for genital warts are inefficient and don’t prevent recurrence.

continued

**Tomorrow's patient
will likely receive
these new vaccines
through novel
delivery methods.**

response. She also studies other aspects of leishmaniasis, including the possibility of a genetic tendency toward the development of visceral leishmaniasis.

Wilson and John Donelson, UI professor of biochemistry and Howard Hughes Medical Institute investigator, are examining a surface protein on the parasite that appears to be associated with its virulence.

She and Dr. Bradley Britigan, UI professor of internal medicine, are also studying how the parasite enters a macrophage and how it is able to survive the toxic materials that the macrophage produces to kill it.

Innovative ways to immunize

Tomorrow's patients will likely receive these new vaccines — as well as today's proven vaccines — through novel delivery methods.

"Using adjuvants, such as microscopic beads with pores, vaccines could be delivered through timed release over the long term. For example, a newborn infant in the nursery would receive a multicomponent vaccine that releases its ingredients at specified times, thus eliminating the need for repeat inoculations," Dr. Apicella explains.

Vaccines based on attenuated bacteria will also give way to oral vaccines.

"Once ingested, the vaccine enters the lymphatic sites in the gastrointestinal tract and creates immunity," Dr. Apicella says.

The preventive potential of new vaccines may offer solutions to some of today's medical challenges.

"It's clear that antibiotics have limited

usefulness due to the growing ability of bacteria to become resistant," Dr. Apicella concludes.

Therefore, regardless of how they are delivered, vaccines will play an ever increasing role in the "big picture" of public health. **IM**

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The Journal

of the Iowa Medical Society



Sports medicine education in the U.S.

● DANIEL FICK, MD; DAVID TEARSE, MD

Sports Medicine is a broad area of health care which includes: 1) exercise as an essential component of health throughout life; 2) medical management and supervision of recreational and competitive athletes and all others who exercise and 3) exercise for prevention and treatment of disease and injury. The practice of sports medicine is the application of the physician's knowledge, skills and attitudes to all persons engaged in sports and exercise.

In 1987, Marion Alberts, MD, *Iowa Medicine* scientific editor, voiced concern over the care of high school athletes.¹ He specifically listed inadequate examination of athletes, poor facilities and exploitative coaches and parents. He felt there was a need to educate and train those who care for athletic programs. At the time of Dr. Alberts' original editorial, there was little if any organized sports medicine education in medical schools. As recently as 1988, Whitley and Nyberg documented only five of 105 medical schools offered a sports medicine course to medical students.²

Seven years later, it seems as if sports medicine has literally exploded in popularity and profit. Unfortunately, this has created a situation where sports medicine advice and services do not come from the medical profession. Whitley and Nyberg noted that information and treatment programs often comes from the news media, health establishments and self proclaimed experts. These "experts" often have little education, training, or experience in sports medicine. Their motivation is commercial and not based in scientific fact.

Physicians are the best source of information and services in sports medicine today. As experts in this field, we must take a leadership

position. However, if we are to do this, there has to be undergraduate education in sports medicine. We have to educate tomorrow's sport physicians while they are medical students. Early exposure and education to medical students in the field of sports medicine will eventually produce doctors with training and expertise which will allow them to provide sports medicine care in a professional and appropriate manner.

How has sports medicine's current popularity affected sports medicine curriculum in U.S. medical schools? How many U.S. medical schools have sports medicine courses and which departments are offering the courses?

To answer these questions, we collected information from all 126 U.S. medical schools. Sports medicine electives were offered in 61 (48.4%) medical schools; 41 (57%) of these were public schools and 20 (37%) were private schools. There were 71 different listings at these 61 medical schools. Eight medical schools listed more than one separate elective; six listed two courses and two listed three separate courses. Most courses were offered by the departments of orthopaedics (66%). Primary care departments offered 28.1%. The course descriptions provided by the catalogues varied significantly (see Table 1 next page).

We found that U.S. medical schools have responded to the sports medicine demand with a 14-fold increase in courses over the last five years. What started out as five courses in 1988 has grown to over 70 courses in 1993. Three out of 10 courses are primary care (family practice and pediatrics) in focus.

While orthopaedics has traditionally been the leader in sports medicine, primary care physicians are becoming more involved and contributing increasing numbers to the ranks of sport physicians. Several recent develop-

The IMS Education Fund has designated this article as the Henry Albert Scientific Presentation Award for April 1995.

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Dr. Tearse is with the Department of Orthopaedic Surgery, University of Iowa College of Medicine.

Sports medicine education in the U.S.

continued

ments in primary care sports medicine has helped move the specialty forward in the last five years. Membership in the American Medical Society for Sports Medicine (AMSSM), the sister organization to the American Orthopaedic Society for Sports Medicine (AOSSM), is increasing. The boards of family practice, internal medicine, pediatrics and emergency medicine offered the first Sports Medicine Certificate of Added Qualification in the fall of 1993. Primary care sports medicine fellowships have been increasing in number and ACGME guidelines for primary care sports medicine fellowship accreditations will be published soon.

TABLE 1
CONTENT OF SPORTS MEDICINE ELECTIVES

<i>Activity</i>	<i># of courses that listed activity</i>
Fieldside participation	29
Operative assistance	28
Training room visits	21
Required reading	17
Conferences	13
Research or literature review	17
Organized lectures	10
Formal student evaluation	19

The comparison of orthopaedics and primary care raises an important issue — cooperation of primary care and orthopaedics. The authors of this article represent both primary care and orthopaedic surgery. Recently, primary care has become part of the sports medicine service that cares for over 200 Division I athletes, in addition to thousands of high school and recreational patients each year. This cooperation has been mutually beneficial for both specialties. With competition from non-medical sources it is imperative physicians work together to provide sports medicine care to student athletes.

The University of Iowa offers medical students the option of sports medicine electives in both orthopaedic surgery and family practice. Sports Medicine education must begin in our medical schools if we want to provide Iowa student athletes with well trained and knowledgeable physicians. **IM**

References

1. Alberts, ME: Sports medicine: *Iowa Medicine* 1987;77:453.
2. Whitley, JD and Nyberg, KL: Exercise medicine in medical education in the United States. *Phys Sportsmed* 1988;16(10):93-101.

As life passes by

Life can only be understood backwards, but it must be lived forward.

Sören Kierkegaard, Danish scholar, (1813-1855)

Life is not dated merely by years. Events are sometimes the best calendars.

Benjamin Disraeli (1804-1881)

These quotations exemplify the experiences in our home during the past few days. We have been sorting hundreds of slides and prints taken of family members and vacation places over the years. It is a tedious task; yet an enjoyable one. A half century of marriage has provided numerous memories now brought to mind by viewing the pictorial records of the past.

Recollection of events in the childhood years of our four children has provided a kaleidoscopic trip through the past. The joys of parenthood interwoven with the adventures of childhood have been renewed. There is the photograph of our youngest while in an incubator that provided him warmth and security during the first weeks of his life. Another photograph recalls the home-runs

by our oldest son while a Little Leaguer. Another reminds us of our youngest daughter during her bout with chicken pox. And, another of our oldest daughter in a beautiful blue gown ready for her senior prom.

I am sure many of my older readers have experienced the recollection of memories depicted by collections of slides and prints . . . collections stashed away in projector trays,

photo albums, boxes and sometimes in the same envelope in which the photographs were delivered from the processors. Of course there are some of you who have catalogued and filed your photographic collections ready to be shown at any time. But, when? Most of us shoot the pictures, have the film developed, review the photos and put them into a drawer, seldom to be viewed again.

Our lives are much like these collections of photographs. Memories imprint a view of past events in our minds when we allow it. As Kierkegaard said "Life can only be understood backwards". We can look back to the joyous events of the past (yes, the unhappy events as well) and relive life as we knew it. Yes, again as Kierkegaard goes on to say, "but it [life] must be

**We can
make our
entire
existence
more joyful
and fulfilling.**

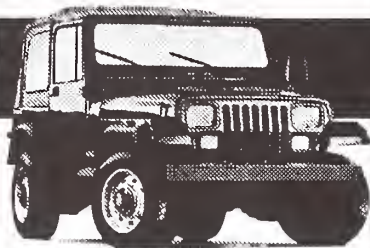
lived forward". I believe, we can make our entire existence more joyful and fulfilling. So many persons harbor depressive attitudes about their past that their present dictates misery in the future. The difficult events of the past often caused concern, but were less dire than anticipated at the time.

Life goes on. Cicero, the Latin philosopher, said, "The life given us by nature is short, but the memory of a well-spent life is eternal." Enjoy life. Look upon the past as experience with good and bad memories. Look forward to the future with anticipation, planning for a continuation of events and joys that in a split second will become part of the past. **IM**



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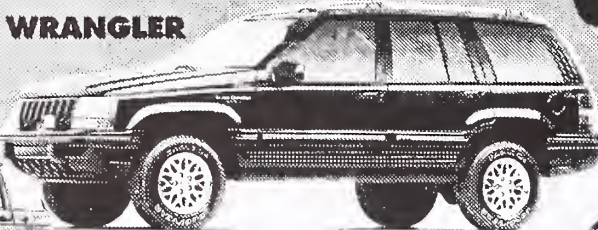


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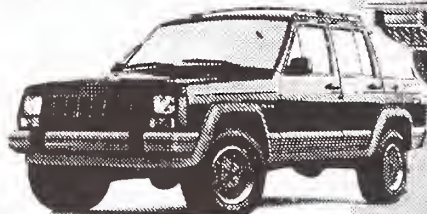
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Retraining physicians for primary care

There is much concern about physician workforce imbalance. While some states and regions find it difficult to recruit primary care physicians and certain medical specialists, other information suggests we face an increasing surplus of physicians. Within recent years a number of studies and commissions have recommended that the nation aspire to training as many generalists as medical and surgical specialists. If such a proportion is to be achieved, approximately 70% of graduating physicians from this time forward would need to enter a true primary care discipline to attain the 50/50 goal by the year 2020.

In the interim, physician unemployment (or at least underemployment) may become part of the American medical marketplace. In the United States this phenomenon has probably been less noticeable since physicians have been willing to relocate from high-density medical areas to other regions of the country. In a growing number of cases, physicians who choose to remain may accept static or reduced compensation as a price for practice stability. There is anecdotal evidence that newly-minted subspecialists may be experiencing difficulty obtaining any suitable position regardless of their flexibility.


These observations have led to serious discussions about physician retraining. While some proposals have centered on the retraining of medical or surgical specialists to provide generalist care, most of the interest is focused on the

retraining of subspecialists to provide more primary care-oriented services. A recent article by Wall and Saultz in *Academic Medicine* (April, 1994) described four pathways for retraining available to the practicing physician. The first is formal residency training in the new discipline leading to board certification. A second involves an organization, presumably a certifying medical or surgical specialty, granting some type of certification of qualification for an individual obtaining post-residency training. In a third pathway, a specific institution might certify the individual to provide medical care at that institution. Finally, an informal apprenticeship pathway is described.

Within continuing medical education circles there is a current effort to develop model curricula for at least the third and fourth pathways.

Newly-minted subspecialists may be experiencing difficulty obtaining any suitable position.

Any such programs would need to be constructed carefully to meet concerns of licensing boards and hospitals or clinics in which physicians might practice their "new" discipline. It is possible that demonstration education programs may be developed in these areas, although the lack of comprehensive national health care reform suggests that further marketplace evolution may be needed.

Physician retraining is an idea whose time may not yet have come, but nevertheless an idea that will be with us until the physician workforce maldistribution improves. 



RICHARD NELSON, MD

Classified Advertising

Mankato Clinic, Ltd.—A progressive group practice is seeking additional BE/BC physicians in the following specialties: acute/urgent care, family practice, oncology/hematology, orthopedic surgery and general internal medicine practice. The Mankato Clinic is a 70-doctor multispecialty group practice in south central Minnesota with a trade area population of +250,000. Guaranteed salary first year, incentive thereafter with full range of benefits and liberal time off. For more information, call Roger Greenwald, Executive Vice President, at 507/389-8500 or Byron C. McGregor, Medical Director, at 507/389-8548 or write 1230 East Main Street, P.O. Box 8674, Mankato, Minnesota 56002-8674.

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Emergency Medicine, Des Moines, Iowa—Opportunity to join an established emergency medicine practice at Iowa Lutheran, member of the Iowa Health System. BE/BC in emergency medicine or primary care specialty with experience. Call me to learn more about our department and generous compensation package. Contact Larry J. Baker, DO, FACEP, 700 E. University, Des Moines, Iowa 50316; 515/263-5263.

Minneapolis, MN—Opportunities available for BE/BC family practitioners with OB to join 6 person group. Western Minneapolis suburb. No practice buy-in required. Excellent salary and benefits. Please send CV or call Nancy Borgstrom, Aspen Medical Group, 1021 Bandana Boulevard East #200, St. Paul, Minnesota 55108, 612/642-2779 or fax 612/642-9441. EOE.

Madison, Wisconsin—Dean Medical Center, a 300-physician multispecialty group, is seeking additional family physicians to join its 30-member department. Positions are located at our Arcand Park, East Madison and Deerfield Clinic locations. All positions have an excellent call schedule and obstetrics is optional. Madison is the home of the University of Wisconsin with enrollment of over 40,000 students and the state capital. Abundant cultural and recreational opportunities are available year round. Excellent compensation and benefits are provided with employment leading to shareholder status. For more information contact Scott M. Lindblom, Dean Business Office, 1808 West Beltline Highway, PO Box 9328, Madison, Wisconsin 53715-0328, work at 1/800-279-9966, 608/259-5151 or at home 608/833-7985. An Equal Opportunity Employer.

Janesville, Wisconsin—Dean Medical Center, a 300-physician multispecialty group, is actively recruiting additional BE/BC internal medicine physicians to practice at the Riverview Clinic locations in Janesville, Milton and Delavan, Wisconsin. Traditional internal medicine and urgent care practice opportunities are available. Janesville, population 55,000, is a beautiful, family-oriented community with excellent schools and abundant recreational activities. Excellent compensation and benefits are provided with employment leading to shareholder status. Send CV to Stan Gruhn, MD, Riverview Clinic, PO Box 551, Janesville, Wisconsin 53547 or call 608/755-3500. An Equal Opportunity Employer.

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Sioux City—An excellent position is available for a BC/BE family practice physician in a new community health center. A full range of family practice medicine is needed in a community that is very supportive of the center. Sioux City is a great place to raise a family and has excellent public and parochial school systems, a community college, 2 liberal arts colleges, a graduate center, 2 excellent medical centers, a Residency Training Program (family practice), etc. The center offers a competitive compensation and benefit package, paid malpractice, etc. **FEDERAL LOAN REPAYMENT PROGRAM AVAILABLE.** For more information write Jeff Hackett, Executive Director, Siouxland Community Health Center, PO Box 2118, Sioux City, Iowa 51104-0118 or call 712/252-2477.

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Janesville, Wisconsin—Dean Medical Center, a 300-physician multispecialty group, is actively recruiting additional BE/BC family physicians to practice at the Riverview Clinic locations in Janesville, Milton and Delavan, Wisconsin. Traditional family practice and urgent care opportunities are available. Janesville, population 55,000, is a beautiful, family-oriented community with excellent schools and abundant recreational activities. Excellent compensation and benefits are provided with employment leading to shareholder status. Send CV to Stan Gruhn, MD, Riverview Clinic, PO Box 551, Janesville, Wisconsin 53547 or call 608/755-3500. An Equal Opportunity Employer.

Madison, Wisconsin, Urgent Care—Dean Medical Center a 300+ physician multispecialty group is seeking full time physician to assist in staffing our two urgent care centers. Qualified applicants should be BE/BC in family practice, emergency medicine or internal medicine with experience in pediatrics. Dean Medical Center operates two Urgent Care Centers 365 days per year, from 7:00 a.m.–10:00 p.m. All physicians employed at the urgent care centers are paid on an hourly basis and full time physicians are eligible to go on a shareholder track and buy into the corporation after two years of employment. Excellent compensation and benefits with shareholder eligibility after two years of employment. For more information contact Scott M. Lindblom, Dean Medical Center, 1808 W. Beltline Highway, PO Box 9328, Madison, Wisconsin 53715-0328, at work 1/800-279-9966 or 608/259-5151 or home 608/833-7985.

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Janesville, Wisconsin, Urgent Care—
 Riverview Clinic, a division of Dean Medical Center, is actively recruiting an urgent care physician to join its medical staff. We recently increased our compensation package which is based on a 40-hour work week. Total compensation for Year 1 \$108,000, Year 2 \$134,642 and Year 3 \$135,000. We currently have two physicians which staff the clinic from 9:00 a.m.–9:00 p.m. Monday through Friday and 9:00–11:30 a.m. on Saturday and desire to expand the hours of operation until 9:00 p.m. on Saturday and 1:00–9:00 p.m. on Sunday. Our facility is brand new and well equipped with 8 exam rooms, lab and x-ray. Flexible hours are available with an expected total of 30–40 hours per week. Excellent compensation and benefits are provided. For more information contact Scott M. Lindblom, Dean Medical Center, 1808 West Beltline Highway, Madison, Wisconsin 53713, work phone 1/800-279-9966 or 608/259-5151, fax 608/259-5294, home 608/833-7985.

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*Certified by American Board of
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Acute Care, Inc.
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*Comprehensive Emergency Medicine
Practice, Locum Tenens,
Doctor on Call*

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*Specialists in Emergency
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*Locum Tenens
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Daniel J. Schroeder, MD
Ravi K. Vemuri, MD
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Des Moines 50325-7072
24 Hours 515/224-1777

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*Reproductive Endocrinology/Infertility
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Artificial Inseminations
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Cardiology
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515/574-6840
Gastroenterology
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General Internal Medicine
William C. Robb, MD
Richard H. Brandt, MD, ABIM
Grace Z. Ang, MD
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Fort Dodge 50501
515/574-6820

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Laurence S. Krain, MD
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Cedar Rapids 52401
319/398-1721
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and Sleep Studies*

Fort Dodge Medical Center, PC
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800 Kenyon Road
Fort Dodge 50501
515/574-6845

Neurosurgery

**Iowa Medical Clinic
Neurosurgery**
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Cedar Rapids 52401
319/366-0481
Practice limited to Neurosurgery

Hosung Chung, MD
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Waterloo 50702
319/232-8756; fax 319/232-5703
Practice limited to Neurosurgery

Neurosurgical Services LLP

Robert Hayne, MD

Thomas A. Carlstrom, MD

David J. Boarini, MD

1215 Pleasant, Suite 608

Des Moines 50309

515/241-5760

Robert C. Jones, MD

S. Randy Winston, MD

Douglas R. Koontz, MD

2600 Grand Avenue, Suite 210

Des Moines 50312

515/283-2217

Neurological Surgery

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Cedar Rapids 52402

319/363-4622

Neurological Surgery

Obstetrics/Gynecology

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Fort Dodge 50501

515/574-6870

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John M. Graether, MD

Gilbert W. Harris, MD

James A. Davison, MD

Norman F. Woodlief, MD

Eric W. Bligard, MD

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Todd W. Gothard, MD

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Marshalltown 50158

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West Des Moines 50266

515/223-8685

804 South Kenyon Road, Suite 100

Fort Dodge 50501

515/576-7777

Sartori Professional Building

516 South Division Street

Cedar Falls 50613

319/277-0103

214 - 13th Street Southeast

Cedar Rapids 52403

319/362-8032

Ophthalmic Associates, PC

Robert D. Whinery, MD

Stephen H. Wolken, MD

Robert B. Goffstein, MD

Lyse S. Strnad, MD

540 E. Jefferson, Suite 201

Iowa City 52245

319/338-3623

North Iowa Eye Clinic, PC

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Michael L. Long, MD

Bradley L. Isaak, MD

Randall S. Brenton, MD

James L. Dummett, MD

3121 4th Street, S.W.

P.O. Box 1877

Mason City 50401

515/423-8861

Timothy F. Moran, Jr., MD

United Federal Building

700 4th Street, Suite 305

Sioux City 51101

712/252-4333

Satellite Clinics

Horn Memorial Hospital

700 E. 2nd Street

Ida Grove 51445

712/364-3311

Orange City Hospital

400 Central Avenue NW

Orange City 51041

712/737-2426

General Ophthalmology

Orthopaedics

Iowa Orthopaedic Center, PC

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Marshall Flapan, MD

Sinesio Misol, MD

Joshua D. Kimelman, DO

Timothy G. Kenney, MD

Lynn M. Lindaman, MD

Jeffrey M. Farber, MD

Kyle S. Galles, MD

Scott A. Meyer, MD

Cassim M. Igram, MD

Donna J. Bahls, MD

Jill R. Meilahn, DO

Jaqueline M. Stoken, DO

411 Laurel, Suite 3300

Des Moines 50314

515/247-8400

Orthopaedic Surgery

Fort Dodge Medical Center, PC

C. Mark Race, MD

800 Kenyon Road

Fort Dodge 50501

515/574-6880

Otolaryngology

Iowa ENT, PC

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Marshall C. Greiman, MD

Steven R. Herwig, DO

Thomas O. Paulson, MD

Mark K. Zlab, MD

1-800/248-4443

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Des Moines 50309

515/241-5780

1200 35th Street, Suite 200

West Des Moines 50266

515/225-7761

Satellite Clinics:

Pella, Perry, Newton, Indianola,

Oskaloosa, Guthrie Center, Knoxville

Wolfe Clinic, PC

Michael W. Hill, MD

Daniel J. Blum, MD

309 East Church

Marshalltown 50158

515/752-1566

Lakeview Medical Park

6000 University Avenue, Suite 310

West Des Moines 50266

515/224-9533

Sartori Professional Building

516 South Division Street

Cedar Falls 50613

319/277-3105

Otolaryngology-Head and Neck Surgery,

Facial Plastic Surgery, Allergy

Phillip A. Linquist, DO, PC

1000 Illinois

Des Moines 50314

515/244-5225

Ear, Nose and Throat Surgery,

Facial Plastic Surgery, Head

and Neck Surgery

(Continued next page)

Professional Listing Rates

Physician members of the Iowa Medical Society may advertise in this directory. Monthly rates are as follows: \$10.00 first 3 lines; \$2.00 each additional line. Billed yearly. May be prorated. Send or fax copy to Iowa Medical Society, 1001 Grand Avenue, West Des Moines, Iowa 50265-3599, fax 515/223-8420.

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Eugene Peterson, MD
Richard B. Merrick, MD
Peter V. Boesen, MD
Robert R. Updegraff, MD
 3901 Ingersoll
 Des Moines 50312
 515/274-9135

Dubuque Otolaryngology-Head & Neck Surgery, PC

Thomas J. Benda, Sr., MD
James W. White, MD
Craig C. Herther, MD
Thomas J. Benda, Jr., MD
 310 North Grandview Avenue
 Dubuque 52001
 319/588-0506

Otologic Medical Services, PC

Roger A. Simpson, MD
Guy E. McFarland, MD
Thomas F. Viner, MD
Douglas E. Dawson, MD
 540 E. Jefferson, Suite 401
 Iowa City 52245
 319/351-5680
 1-800/642-6217

*Maxillofacial, Plastic, Head & Neck
 Surgery*

Robert G. Smits, MD, PC

1040 5th Avenue
 Des Moines 50314
 515/244-8152
 1-800/622-0002
*Ear, Nose and Throat Surgery,
 Facial Plastic Surgery and Head and
 Neck Surgery*

Pain Management**Iowa Medical Clinic Outpatient Pain Treatment Center**

James R. LaMorgese, MD, FACS,
Neurosurgeon, Medical Director
**Sandra Gannon, LSW, ACSW, Program
 Director**

600 7th Street SE
 Cedar Rapids 52401
 319/399-2013

*Neurology, Psychiatry, Anesthesiology,
 Rheumatology*

Physical Medicine & Rehabilitation**Genesis Regional Rehabilitation Center
 Genesis Medical Center**

1227 East Rusholme Street
 Davenport 52803
 319/383-1466

Maurice D. Schnell, MD
Fareeduddin Ahmed, MD
Arthur B. Scarle, MD
Bogdan E. Krysztofiak, MD

Rehabilitation Medicine Associates

William D. deGravelles, Jr., MD
Charles F. Denhart, MD
Marvin M. Hurd, MD
William C. Koenig, Jr., MD
Karen Kienker, MD
Todd C. Troll, MD
Lori A. Sapp, MD
Yunker Rehabilitation Center
Iowa Methodist Medical Center
 1200 Pleasant
 Des Moines 50308
 515/241-6434

2600 Grand Avenue, Suite 102
 Des Moines 50312
 515/283-1570

Pulmonary Medicine**Fort Dodge Medical Center, PC**

Robert C. Ang, MD, FCCP
 800 Kenyon Road
 Fort Dodge 50501
 515/574-6820

**Chest, Infectious Diseases & Critical Care
 Associates, PC**

Roger T. Lin, MD
Steven G. Berry, MD
Donald L. Burrows, MD
Michael Witte, DO
Gerard A. Matysik, DO
 1601 NW 114th, Suite 347
 Des Moines 50325-7072
 24 Hour 515/224-1777

Pulmonary Diseases

Surgery**Wendell Downing, MD**

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 Des Moines 50309
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 Rectum*

Fort Dodge Medical Center, PC

Ralph E. Woodard, MD, FACS
Dan P. Warlick, MD, FACS
 800 Kenyon Road
 Fort Dodge 50501
 515/574-6865

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Farewell advice

This is my last column as your president and I must thank everyone who helped me during the past year, especially my wife, Polly, who traveled with me and made me believe she enjoyed it. Thanks also to the IMS staff who helped make my job a little easier.

I can't relinquish this space without encouraging you one last time to stand up for our principles with big government, big business and the insurance industry. Physicians are a force to be reckoned with if we arrive at a consensus in our ranks.

During the past 30 years, government has become consumed with process rather than progress. The cost of "process" in our nursing homes, extended care facilities and hospitals is enormous.

An example is the paper forms required of skilled nursing facilities. For each patient admitted, there are 18 separate forms. More forms are being added. This began with OBRA '87 and has increased each year.

Nursing homes have so many forms to complete that they have difficulty finding the time. In nursing homes, there are 15 forms to fill out for each new patient. Quarterly forms require additional time and care plans are required each week for each patient. No wonder the fastest rising segment of Medicaid costs is nursing home care.

The truly unfortunate aspect of this situation is that none of this paperwork ensures patients are getting better care. They add to

costs and are only important to paper checkers.

Recently, I asked a nurse why nursing homes don't complain. She told me they have complained, but that the bureaucrats don't respond.

This is why it is so important for every physician to become involved at some level and not leave it to the next person.

When you bring your concerns to the IMS House of Delegates in the form of resolutions, you educate your colleagues on the issues of importance to medicine. You also might learn whether your concern is shared by other physicians.

We can all do something to take responsibility for where medicine goes in the future.

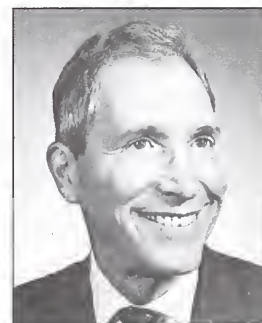
**Physicians are
a force to be
reckoned with
if we arrive
at a consensus
in our ranks.**

During the past year, I attempted to introduce various topics that may lead to action or, at the least, induce people to become informed and write to legislators. In the future, look around in your own communities to find opportunities to make our voice heard.

Is there a light at the end of the tunnel for physicians? I believe there is. Articles and books are starting to appear which indicate increased public awareness of over-regulation of health care and other industries.

However, we must stay educated and involved or we cannot hope to change things for the better.

Thank you for the privilege of serving as IMS president. It has been a memorable year. **IM**



JAMES WHITE, MD

IMS Update

AT A GLANCE

Governor Terry Branstad has reappointed James Caterine, MD and Teresa Mock, MD to the Iowa State Board of Medical Examiners. He has appointed Dale Holdiman, MD of Sioux City to replace George Spellman, MD when Dr. Spellman's term expires.

The 1995 Iowa Family Practice Opportunities Fair will be August 26 at the Savery Hotel and Des Moines Convention Center. The event is sponsored annually by the UI College of Medicine and the Iowa Medical Society.

Dr. Peter Wallace has been nominated to serve on the Iowa Hospital Association Board of Directors. Dr. Wallace is vice president of medical staff affairs at Mercy Hospital in Iowa City. The IHA is attempting to expand non-CEO representation on its board.

New UI emphasis on primary care

Changes in the University of Iowa College of Medicine curriculum will place more emphasis on primary care disciplines, Dr. Richard Nelson told the IMS Board of Trustees during a special meeting last month.

Dr. Nelson, associate executive dean at the UI, also reported that 62% of the new College of Medicine graduates are entering one of four primary care disciplines and 34% are staying in Iowa for residency training.

The IMS Board of Trustees meets annually with UI officials.

House of Delegates survey

As of early April, 347 IMS member physicians answering a recent survey, 240 physicians prefer the IMS House of Delegates meeting be held in Des Moines; 107 would like to see the meeting rotate to locations around Iowa.

With regard to the time of the meeting, 172 prefer a spring meeting and 87 had no preference as to the time of year.

The 1995 House of Delegates was scheduled to receive a report regarding these survey results.

IMS Membership Directory verification

In early June, member physicians will receive a letter which will verify their office addresses, phone and fax numbers, etc. for the 1995-96 IMS Membership Directory. The directory will be distributed next fall to all member physicians, hospitals, chambers of commerce, etc.

Please watch for your verification letter and return it promptly to IMS headquarters. This is essential if the directory is to contain the correct information about your practice.

In addition, IMS members may advertise their practices in a special section of the directory. This advertising section is intended for reference use by member physicians

making referrals and by the public needing medical services.

For details on how to place an ad in the IMS Membership Directory, call Jane Nieland or Bev Corron at IMS headquarters, 515/223-1401 or 800/747-3070. If you placed an ad in last year's directory, you will receive a renewal form.

SPECIALTY SOCIETY UPDATE

The IMGMA Spring Meeting was May 3-5 at the Des Moines Marriott. Fritz Wenzel, executive director of MGMA, spoke on the future of medical group management. Greg Ganske discussed his first 100 days in Congress.

The transition to Medco Behavioral Health operating the Medicaid mental health benefits for the state of Iowa is causing concern among Iowa psychiatrists. Problems with receiving approvals for inpatient services have caused delays. Contracts sent to Iowa psychiatrists have also caused concern. A task force has been established to seek modifications. (For more on this issue, see the *Futures* section of this magazine.)

The American Medical Directors Iowa Chapter held its spring meeting at the Airport Holiday Inn. Morris Green, MD, PhD, AMDA president spoke on anxiety in the elderly. David Folks, MD spoke on depression in the geriatric patient.

The Iowa Society of Anesthesiology held its annual meeting Saturday, April 1. Over 70 physicians from Iowa and Nebraska attended. Keynote speaker was Norig Ellison, MD, president-elect of the American Society of Anesthesiologists.

The Iowa Radiological Society held its annual meeting April 1-2 in Iowa City. The program covered interventional radiology and current trends in radiology.


The Iowa Society of Rehabilitation Medicine held its spring meeting on Friday, April 7 in West Des Moines. The program included a presentation on CHMIS.

The Iowa Academy of Otolaryngology was represented at Iowa Medicine Day on March 22 by president Dean Lyons, MD. Dr. Lyons discussed bills pending in the legislature on statute of limitations and definition of surgery.

AMA-ERF contributors

Hospital administrators and IMSA members donated \$2,255 to the AMA's Education and Research Fund in honor of physicians on Doctors' Day. Following are the physicians honored by contributors:

Harold Eklund, MD; R. Josef Hofmann, MD; Charles Crouch, MD; Nicholas Messamer, MD; R. Bruce Trimble, MD; Philip Habak, MD; Robert Schulze, MD; Paul Holzworth, MD; Bernard Hoenk, MD; Clifford Rask, MD; Fred Carpenter, MD; Thomas Foley, MD; Dean Ehrecke, MD; John Zittergruen, DO; James Delperdang, MD; Thomas Johnson, MD; Dennis Rolek, MD; Harold Miller, MD; James Bell, MD; James Reed, MD; Ronald Moeller, MD; James Kimball, MD; Robert Bannister, MD; Joseph Veverka, MD; Dwayne Howard, MD; David Howard, MD; David Wall, MD; Kathleen Foster-Wendel, MD; David Gerbracht, MD; Eugene Foss, MD; Kenneth Lyons, MD; Gordon Flynn, MD.

In memorium donations were given for: Dallas Minchin, MD and Robert Foss, MD. Donations were also given in honor of the Genesis Medical Center in Davenport, North Iowa Mercy Health Center in Mason City, Marshalltown Medical and Surgical Center and the Scott County Medical Society Alliance. 

We're At Your Service

For nearly 20 years we've helped Iowa Medical Society members meet the challenges of our ever-changing healthcare environment.

Quality Products: We stock a full line of private-label ABCO alternatives as well as brand-name products at competitive prices.

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Des Moines
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Rockford
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Peoria
(309) 637-6058

Futures

AT A GLANCE

At the AMA Leadership Conference, the AMA announced formation of a formal alliance with the Denver-based Medical Group Practice Association. The groups will remain autonomous with their own governing boards but will work together on common legislative goals, education, research and consulting.

Key congressional Republicans have endorsed a sharp slowdown in the rate of growth of federal health spending, while agreeing to give states almost total control of the Medicaid program. They are convinced states can deliver a more efficient program with less money and have a plan to convert Medicaid spending to a system of block grants.

AMA COMPILES MANAGED CARE STATISTICS FOR IOWA

With the assistance of IMS staff, the American Medical Association has compiled the following Iowa information for inclusion in its Reference Document on Managed Care.

DEMOGRAPHIC INFORMATION	IOWA	US
Population	2,807.6	257,282.9
% population over 65	15.7	12.7
Per Capita Income	\$19,329	\$20,672
PHYSICIAN MARKETPLACE	IOWA	US
Practicing physicians	3,337	439,390
Physicians per 1,000	1.19	1.71
Primary care per 1,000	.46	.58
Per capita spending on physician services	\$483.77	\$687.44
HOSPITAL STATISTICS	IOWA	US
(Community hospitals)		
Total beds	13,653	918,786
Beds per 1,000	4.9	3.6
% bed occupancy rate	58.0	64.4
Average hospital stay	8.1 days	7.0 days

INSURANCE COVERAGE*	IOWA	US
% population with coverage	89.85	85.12
% population/private coverage	80.76	71.42
% population/other public coverage	21.81	25.05
% population with Medicaid	8.53	11.33
% population with Medicare	12.90	13.38

PHYSICIAN GROUPS	IOWA	US
Number of groups	250	16,009
Total number of physician positions in groups	2,757	184,358
Mean (median) group size	11 (5)	12 (5)
% with HMO contracts	65.0	76.5
% of revenues from HMOs	11.7	16.0
% of PPO contracts	64.5	69.3
% of revenues from PPOs	13.4	15.6

LIST OF GROUP PRACTICES WITH OVER 100 PHYSICIANS:

Iowa Clinic
Iowa Physicians Clinic
McFarland Clinic
University of Iowa College of Medicine

* Numbers add up to over 100% because some patients have more than one type of coverage

Medicaid managed care operational here

According to officials of the Iowa Psychiatric Society (IPS), the Medicaid mental health managed care contract being implemented by Medco is now operational in Iowa, and Iowa psychiatrists have been contacting the IPS office with problems and concerns.

To date, problems have occurred with contract provisions, operational difficulties such as lack of telephone access and billing and coding procedures.

However, patient concerns have been primary with many IPS members expressing concerns regarding patient care issues and difficulty in obtaining authorization to admit patients to the hospital. In response to these calls, the IPS office has established an incident file which will be discussed with Medco.

IPS officials have been told that criteria for evaluating the success of the managed mental

health program will be based in part on the number of appeals filed by doctors on utilization review decisions.

Officers of the IPS met recently with Iowa legislators and Medco representatives. At that meeting, Medco representatives said they will institute a Providers Round Table which will meet every two weeks to discuss matters of concern.

For more information on these issues, call Dana Petrowsky, executive director of the IPS, at 800/728-5398.

Scorecard of Iowa reforms

Following was the status of health system reform initiatives in Iowa:

1. Purchasing reform — Enables individuals or small groups to combine purchasing power, also known as HPCs. IMPLEMENTED.

2. Delivery reform — Groups of providers

"You Asked for It! We Have It!"

Specialty Coding Extravaganza

RESCHEDULED DATES

Date: June 13 and 14, 1995

Time: 8:30 a.m. to 4:30 p.m.

Where: Best Western Des Moines International,
1810 Army Post Road, Des Moines

Because of unforeseen complications for our presenter, Nancy Maguire, we have decided to reschedule the program to Tuesday, June 13, and Wednesday, June 14. Fortunately, Nancy Maguire and the Best Western Des Moines International are available.

TUESDAY, JUNE 13, 1995—TERRACE ROOMS 1 & 2

8:30 a.m. to 4:30 p.m.—PEDIATRIC AND PRIMARY CARE CODING

Don't miss this opportunity to get the right answers to your difficult coding questions. This seminar will help you with practical advice to avoid reimbursement pitfalls. Use E & M codes correctly the first time and avoid common mistakes.

WEDNESDAY, JUNE 14, 1995—TERRACE ROOM 4

8:30 a.m. to 4:30 p.m.—ALL SURGERY

Includes orthopaedic, neurosurgery, ENT and general surgical coding. You, too, can bill the right surgical codes every time and avoid duplication and unbundling edits. Find out when to use those tricky modifiers. Discussion will be based on actual operative notes.

COST:

1 full day: \$175 for IMS member or staff, \$280 for non-member or staff

2 full days: \$320 for IMS member or staff, \$530 for non-member or staff

For hotel reservations call the Best Western Des Moines International at 515/287-6464. Be sure to give the seminar name for special rates. Maps are available upon request.

Continental breakfast, break
refreshments and lunches will
be furnished both days.

Registration Form

SPECIALTY CODING SEMINAR—REGISTRATION DEADLINE IS JUNE 1

Name(s): _____

Clinic/Practice Name: _____

Address: _____

Phone: _____ **Fax:** _____

Amount Enclosed: _____ **Date:** _____

Please make checks payable to IMS SERVICES. Mail check and registration form to:
IMS SERVICES, ATTN: Sherry Johnson, 1001 Grand Avenue, West Des Moines, IA 50265-3599

combining in newly permitted ways to provide comprehensive services to consumers in a capitated environment, called organized delivery systems. IMPLEMENTED.

3. Employer access — Employers are required to provide workers with information about where they can receive health benefits. RULES BEING FINALIZED.

4. Small group insurance reform — Redefines small group to 2-50 individuals, standardized benefit packages, changes in rating practices, elimination of pre-existing conditions, guaranteed access and portability. IMPLEMENTED.

5. Individual insurance reform — Provides individuals with same protections afforded small group insureds. SIGNED BY GOVERNOR.

6. Tax equity — Enables individuals to deduct 100% of out-of-pocket insurance premiums from state income taxes. SIGNED BY GOVERNOR.

7. CHMIS — Electronic filing and billing, data repository for health data collection. GOES INTO EFFECT FOR PROVIDERS JULY 1, 1996.

8. Statewide health accounting system — Enables detailed tracking of health care income, expenditures and outcomes; request for proposal has been issued to help establish system. AUTHORIZED IN 1994.

9. Report cards — HIPCs required to produce their own; state required to provide on ODSs. IMPLEMENTED.

10. Telemedicine — Using transmission networks to enable physicians in different locations to consult on problems, particularly useful in rural or remote areas. IMPLEMENTED.

11. Recruiting and retaining providers — Special efforts to attract health care providers to particular areas of the state and induce-ments for them to stay. IMPLEMENTED.

12. Standard benefits package — RULES FILED.

13. Medical liability reform (As of press time, this was pending in the 1995 Iowa Legislature) — Reduction in statute of limitations for minors to six years plus two years.

14. Medical savings accounts — PENDING IN 1995 IOWA LEGISLATURE.

Managed care developments

The following information is provided by the American Medical Association.

•For the third consecutive year, California Public Employees Retirement System has negotiated a premium reduction from 22

California HMOs. The 5.2% reduction for 1995-96 tops last year's reduction of 1.1% and brings premiums to their 1991 levels.

•The Foster-Higgins survey of employer sponsored health plans found that in 1994, the employer expenditure for health benefits declined an average of 1.1%. In the Northeast, a decline of 9.7% is attributed to a jump in managed care enrollment from 34% to 63%.

•UpJohn has developed Greenstone Healthcare Solutions, a disease management unit offering hospitals and managed care organizations programs to determine patient health risk and optimal treatment options. Pharmaceutical companies view disease management as a potential revenue source.

•A recent study of 20,000 consumers in 20 markets found that 83% of respondents in HMOs are satisfied with their plans compared to 77% in fee-for-service and 76% in PPOs. However, HMO patients were less satisfied with access to referrals.

•PPOs reduced their physician panels by an average of 8% between 1992-93 and cut hospital contracts by 22%.

Gingrich calls for investigation

During the AMA's recent Leadership Conference in Washington, DC, House Speaker Newt Gingrich called for a congressional investigation of the managed care industry, the fastest growing and most controversial sector of the nation's health care system. Gingrich's call for hearings was cheered by doctors. Managed care is coming under increasing fire for being dominated by bean counters more concerned about the bottom line than the quality of care.

Gingrich met privately with AMA officials and he later expressed concern over anecdotes in the news about patients not receiving proper care. James Todd, MD, AMA executive vice president, said the AMA is "very much in favor of hearings".

Financing physician ventures

In this month's *Iowa Medicine* feature on page 202, Steve DeNelsky, senior financial consultant with Medical Alliances in Alexandria, Virginia, discusses financing of physician managed care ventures — options available and steps necessary to obtain financing. **IM**

**Newt Gingrich
called for a
congressional
investigation of the
managed care
industry.**

Legislative Affairs

AT A GLANCE

U.S. Representative Greg Ganske has teamed with an Oregon Democrat to introduce legislation which would prohibit patenting of medical and surgical procedures. The measure has the strong support of the AMA.

President Clinton has signed into law a bill giving more than three million self-employed people the right to deduct their health insurance costs from their taxes. Part of the bill lets the self-employed deduct 25% of the cost of health insurance premiums for themselves and their families.

Key bills survive second funnel

The legislature is nearing the end of the 1995 session. Following is an update on the status of key bills of interest to the IMS.

Statute of Limitations

The IMS statute of limitations bill passed the House this year but was not brought out of the Senate Judiciary Committee. It will still be eligible for Senate consideration during the 1996 session. The IMS plans to continue to work with senators on this issue. Physicians are encouraged to meet with local senators and discuss this and other issues over the summer and fall.

Any Willing Provider

The "any will provider" bills are dead for the session unless offered as amendments to other bills.

Definition of Surgery

The IMS bill to define surgery was killed for the session. After approval by the Senate Human Resources Committee it was referred to the Senate State Government Committee which failed to approve it.

Uniform Anatomical Gift Act—SF 117

The bill updating the Uniform Anatomical Gift Act passed both houses and will be sent to the governor for consideration. The bill was initiated by the Iowa Statewide Organ Procurement Organization which worked with the Iowa Medical Society, the Iowa Hospital Association and the Iowa State Bar Association. SF 117 updates current Iowa organ donation law which was adopted in 1983. More details about the new law will be provided in the July issue of *Iowa Medicine*.

Trauma System—SF 118

SF 118 has passed both houses and is on its way to the governor for approval. The bill establishes a structure for a statewide trauma designation system for hospitals. There will

be no restrictions on the types of services that may be provided by any hospital. A Trauma System Advisory Council consisting of physicians, hospital representatives and other health personnel will implement the plan.

The bill was developed by the Iowa Trauma Systems Development Project Planning Consortium in conjunction with the Iowa Department of Public Health with the intent of insuring the coordination of the various components of Iowa's trauma services.

Prior Authorization of Certain Prescription Drugs Under Medicaid—SF 462

As a cost saving measure within the state's Medicaid program, the Department of Human Services appropriation bill contains a requirement that for drugs where a generic bioequivalent exists (using the FDA's "A" list of generic bioequivalents) prior authorization will be required for the brand name drugs.

Prior authorization will not be required for the generic. IMS physicians have done a preliminary review of the list to ensure that it does not contain drugs where the brand name is preferred for medical reasons. We will have another opportunity to review the list in detail during the administrative rulemaking process. This provision will go into effect September 1.

Reimbursement for Obstetrical Care—SF 462

Medicaid reimbursement for obstetrical care will increase by 5% beginning July 1, if SF 462 is approved in its present form.

Public Health Bills Unsuccessful

This year was generally not a good year for public health bills. Tobacco and motorcycle/bicycle helmet bills received approval by the Senate Human Resources Committee but were all referred to less favorable committees.

Getting Tough on Drunk Drivers

Unlike most public health bills, SF 446, which cracks down on drunk drivers, has passed both houses; Governor Branstad has

expressed support for SF 446 and is expected to sign it. It requires a 30-day license revocation for underage drinkers (under 21, the legal drinking age) who drive with a blood alcohol concentration of 0.02% or more.

Adults who are convicted of drunk driving must lose their license, with no temporary restricted permit allowed for at least 30 days. Persons convicted of a second or subsequent offense will have the vehicle they were driving impounded or immobilized with an ignition interlock device for the period of license revocation. Provisions are included to allow family members who must use the vehicle. The legislature wanted to send a message that drinking and driving don't mix.

Podiatrist Defined as Physicians

SF 152, renaming podiatrists as "podiatric physicians" has passed both houses.

A complete review of final 1995 legislative action will appear in the June issue of *Iowa Medicine*.

KEY FACTS ABOUT LIABILITY

•The medical liability system costs nearly \$50 billion a year, including \$25 billion for defensive medicine.

• Injured patients receive only 43 cents of every liability dollar. Lawyers get most of what is left.

• Studies show that 60 to 75% of all liability claims have no merit and are settled with no compensation paid. This drives up premiums. Even in cases without merit, physicians often settle out of court to avoid the expense and trauma of a trial.

• Nearly 40% of physicians (78% of OB/GYNs) will have a claim against them during their career, regardless of the quality of care they provide.

• One of eight obstetricians has stopped delivering babies because of the liability system.

AMA scores liability victory in House

*Guest editorial by Robert McAfee, MD
president, American Medical Association*

On March 9, medicine scored one of its biggest legislative victories ever when the House of Representatives, in a bipartisan vote, approved an AMA-backed amendment that would place a \$250,000 cap on pain and suffering awards in medical malpractice cases. This historic vote came as a result of an all-out lobbying effort by your American Medical Association and many other medical organizations. It was a blockbuster victory for the AMA, the medical profession and every practicing physician.

Liability reform has been at the top of medicine's legislative agenda for as long as most of us can remember. Now, after 20 years of tirelessly campaigning, we can claim a major win in Washington.

However, the legislation still has to go before the Senate, where the proposal is sure to be a prime target of the trial lawyers' lobby. So, our task is only half complete. The vote there is likely to take place in the next few weeks and we are asking all of you to contact your senators and let them know where you stand.

Here are some of the things the AMA has done:

•We've mobilized state, county and national specialty societies to join our effort. In late March, we sent a letter to every Senator that was signed by the medical societies in all 50 states and by 81 specialty societies. AMA Alliance sent letters to every county legislative chair in home districts of the Senate Judiciary Committee members, urging them to call and fax their support for liability reform.

•We've gone directly to Capitol Hill. During our National Leadership Conference in Washington, we held a reception for members of Congress and followed that up with one-on-one visits by physicians.

•We've gone public through drive-time ads on Washington's top radio stations, rebutting scare tactics used by trial lawyers. We've placed ads in major newspapers.

The public is listening. A Gallup survey showed more than 71% of Americans favor liability reform, including caps on pain and suffering awards. Clearly, many of our patients are on our side, but we can take nothing for granted.

Tell your patients. Tell your colleagues. Tell your representatives in Congress. The AMA and organized medicine are leading the more than 700,000 physicians of America in the battle for liability reform. Congress must know we will not stop until the job is done.

As this is being written, liability reform is at the top of our priorities. But Medicare reform and the AMA's 1995 Patient Protection Act will also receive attention in the coming days and months.

Together, organized medicine is fighting for legislation that will allow you to care for your patients to the best of your ability and conscience. I invite all of you to join us in that fight. **IM**

For materials suitable for sharing with patients, call the AMA at 312/464-4430.

Medical Economics

AT A GLANCE

Since Oregon passed the nation's first physician assisted suicide law, 12 other states have planned or introduced similar legislation. A federal court last month ruled that states can ban doctor-assisted suicide. Most feel this issue will be resolved by the Supreme Court.

As of press time, the AMA was celebrating a big victory following a vote by the Republican controlled House to limit pain and suffering damages in medical malpractice cases to \$250,000. Lawmakers voted to include the cap as part of a broader bill to limit the amount plaintiffs can collect in product liability suits.

It will be easier for employers to change or cancel retiree health benefits because of a recent Supreme Court ruling. The justices said standard benefit plan wording giving companies the right to amend a plan is valid.

CHMIS activities update

The Iowa Medical Society's Ad Hoc Committee on CHMIS met April 4 to hammer out recommendations on CHMIS policy. The committee's final recommendations were scheduled to be considered by the IMS House of Delegates April 29-30.

Under the CHMIS law, by July 1, 1996, all health care providers must submit claims electronically using a standard format and all payers will be required to accept the standard format. However, many details regarding how the CHMIS will work have not yet been determined by the state CHMIS Governing Board and five advisory committees.

The focus of the April meeting was discussion of IMS policy regarding implementation of CHMIS, Phase I in July of 1996.

The recommended IMS policy was developed in response to physician concerns with confidentiality of patient-specific medical data and the cost to physicians to implement, maintain and participate in CHMIS. The policy also provides guidance for IMS representatives on the five CHMIS advisory committees.

Other points in the proposed policy deal with network certification, coordinating all data collection through CHMIS and maintaining a phased in approach to CHMIS in Iowa.

However, the most critical issues continue to be cost/financing decisions and confidentiality protection.

Several committee members emphasized the importance of physicians staying involved in the CHMIS implementation process to ensure that data about physician practices is used appropriately. This participation will also keep IMS in a position to determine what physician data needs will be in the future and how these needs can be met.

IMS staff and physicians have presented close to 30 CHMIS programs around Iowa. Special programs on CHMIS are available for any group of member physicians. To schedule a program, call Ed Whitver, 515/223-1401 or 800/747-3070.

Ambulatory Care Quality Improvement

The Iowa Foundation for Medical Care (IFMC) has begun a two-year project under its contract with HCFA. The project is called the Ambulatory Care Quality Improvement Project (ACQIP).

ACQIP focuses on collaborative efforts to refine and implement educational and outreach strategies to improve ambulatory care. The project's purpose is to profile practices of care for physician self-examination through information sharing.

Iowa, Alabama and Maryland physicians will evaluate primary and preventive services provided through physician offices to Medicare beneficiaries with diabetes. Mary Nettleman, MD and Richard Osterholm, MD represent Iowa on the national HCFA panel which will develop quality indicators for diabetes. A local Iowa study group has also been formed. This group includes IMS members Steven Craig, MD, Des Moines; John Olds, MD, Des Moines; and Milton VanGundy, MD, Marshalltown.

Primary care physicians will be selected

1995 MEDICARE PREMIUMS, DEDUCTIBLES AND COINSURANCE

Medicare Part A

PREMIUM: \$261 per month for regular entitlement
\$183 per month for reduced premium

DEDUCTIBLE

Hospital: \$716 per benefit period

COINSURANCE

Hospital: \$179 per day (61st through 90th day)
\$358 per day (each "lifetime reserve" day)
SNF: \$89.50 per day (21st through 100th day)

Medicare Part B

PREMIUM: \$46.10 per month
DEDUCTIBLE: \$100 per calendar year
COINSURANCE: 20% of Medicare allowed amount

from Medicare claims data and requested to provide identified medical records for review. IFMC will do the review this fall. Physicians will not need to retrieve data from the records and will be reimbursed for copying and mailing.

Profiles will be created from claims data and sent to volunteer physicians, followed by educational activities. Medicare claims and physician office records will be reviewed to assess the impact of educational efforts regarding care of persons with diabetes.

If you are interested in participating in this project, call Mary Schrader at the IFMC, 800/373-2964.

The death of common sense

A new book called "The Death of Common Sense", which decries the amount of governmental regulation in this country, is a runaway bestseller.

The book's author, Phillip Howard, says he wanted to figure out why everyone who deals with the government has the same reaction

— anger and frustration. The reason, he learned, is that "we've banned judgment".

The book cites many examples of governmental regulation such as OSHA which have given bureaucrats almost "limitless arbitrary power". The GOP Contract With America, Howard says, takes only small steps toward true reform.

IFMC election results

The results of the Iowa Foundation for Medical Care Board of Directors elections have been announced. Nine directors taking office immediately for three-year terms are:

COUNTY	REPRESENTATIVE
Cerro Gordo	Michael Crane, MD, Mason City
Des Moines	Koert Smith, MD, Burlington
Johnson	Karl Larsen, MD, Iowa City
Linn	Jolynn Glanzer, MD, Cedar Rapids
Polk	Peter Boesen, MD, Des Moines
Pottawattamie	Gary DeVoss, MD, Council Bluffs
Story	Elie Saikaly, MD, Ames
District I	John Ellis, MD, Marshalltown
District VII	Stephen Piercy, MD, Fort Dodge 

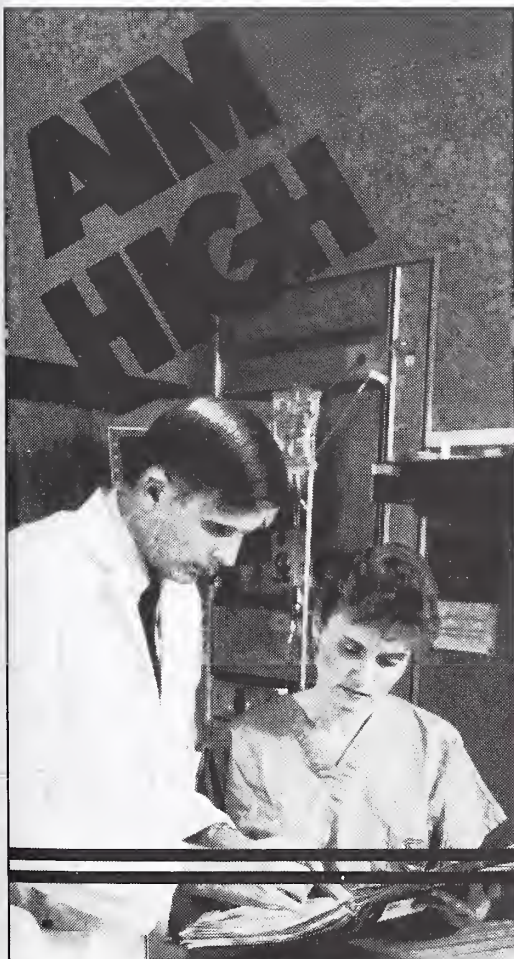
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Practice Management

AT A GLANCE

Don't miss this month's feature article on page 202 for some valuable advice on how to obtain financing for physician managed care ventures.

According to an article in AM News, physicians should become acquainted with certain business skills in order to survive in the world of managed care. The most important is learn to negotiate. Physicians have economic clout because they control patient care. Physicians are advised not to be intimidated by lawyers or MBAs — everything is negotiable, from contracts to compensation.

Seminar discounts!

IMS Services has slashed prices for one class this year (per person) from \$150 to \$99. For purposes of this special offer, choose from *Medical Terminology* in June, *Quality in the Medical Office* in September or *Billing and Collection Strategies* in October.

Look for a discount coupon in the mail in early May for June classes listed in the box below. For more information, call Mary Reinsmoen at IMS Services, 800/728-5398.

Medical Business Specialist program

The first year of the Medical Business Specialist certificate program has been completed. This successful program is meeting the needs of staff in many physician offices across Iowa and the program continues to grow. For more information, call Mary Reinsmoen or Sherry Johnson at IMS Services, 800/728-5398.

Retirement readiness

There is still time to register for a seminar on retirement readiness scheduled for May 24 at IMS headquarters in West Des Moines. The seminar, designed for physicians and their spouses, answers important questions for physicians as they plan for retirement.

For more information, call Mary Reinsmoen at 800/728-5398. **IM**

MIDWEST MEDICAL INSURANCE FOCUS ON RISK MANAGEMENT

Communicating after a bad outcome

A bad outcome during the course of medical care is distressing to the patient and the physician. It can be difficult for a patient to understand that a bad result does not automatically imply negligence.

How do you apologize to a patient after a bad outcome in a way that does not admit liability or negligence? How do you discuss the situation without saying "It's my fault"? How do you say "I'm sorry" without saying "I'm liable"?

An expression of sorrow and an explanation of the bad outcome need not imply either personal responsibility or negligence. While it may not prevent a malpractice claim, an honest, empathetic discussion of the problem within a reasonable time often helps soothe a patient's anger and distrust.

These situations can be extremely difficult to handle and there is no simple rule to follow. The best advice is to call legal counsel and your professional liability insurer for guidance. Any wrongdoing you admit to a patient or a patient's family may be used in court.

For further information, contact Lori Atkinson, MMIC risk management coordinator, MMIC West Des Moines office, PO Box 65790, West Des Moines, 50265, 800/798-9870 or 515/223-1482.

UPCOMING IMS SERVICES SEMINARS FOR YOU

*Medical Terminology

Wednesday, June 7
WEST DES MOINES
Wednesday, June 14
SIOUX CITY
Thursday, June 22
CEDAR RAPIDS

*Office Team Skills

Thursday, June 8, WATERLOO
Wednesday, June 21, DAVENPORT
Wednesday, June 28
WEST DES MOINES
Thursday, June 29, SIOUX CITY

*These seminars are part of the IMS Medical Business Specialist (MBS) certificate program

For more information on any seminar, call Mary Reinsmoen or Sherry Johnson at the IMS, 515/223-1401 or 800/728-5398.

Newsmakers

Awards, appointments, etc.

Dr. Franklin Scamman, associate professor in the Department of Anesthesia, UI College of Medicine and chief of Anesthesiology Service at the Iowa City Department of Veterans Affairs Medical Center, has been named the first director of the newly established National Anesthesia Service for the Veterans Health Administration in Washington, D.C. He will direct the national activities from the Iowa City VA Medical Center. Two UI College of Medicine, Department of Internal Medicine faculty have received Established Investigator Awards from the American Heart Association: **Dr. Kevin Dellsperger**, associate professor and **Dr. Kathryn Lamping**, assistant professor. A photo of **Dr. Enfred Linder's** daughter, **Dr. Jo Ellen Linder**, appeared in the February issue of *LACMA* (Los Angeles County Medical Association) *Physician* magazine. **Dr. David Sommerfeld**, medical director of the Ottumwa-Henry Kidney Dialysis Facility, has been certified as a diplomat of nephrology by the American Board of Internal Medicine. **Dr. Merlin Osborn**, anesthesiologist, has retired after practicing in Cedar Rapids for 27 years. **Dr. Caroline Carney**, Iowa City resident physician, has received the National Institute of Mental Health's Outstanding Resident Physician Award. She was chosen from a nationwide pool of applicants nominated by their residency programs. **Dr. Mark Dillon**, Ottumwa, has begun practice with Internal Medicine, P.C. **Dr. Lester Yen** recently became a diplomate with the American Board of Plastic Surgery. Three longtime anesthesiologists associated with Mercy Hospital Medical Center, Des Moines have retired: **Dr. Donald Sweem**, **Dr. Charles Hull** and **Dr. Marvin Silk**. **Dr. Timothy Ryken**, chief resident in the Division of Neurosurgery, UI College of Medicine, has been named the 1995 VanWegenen Fellow by the American Association of Neurological Surgeons. **Dr. Donald Berg**, orthopedic surgeon with Ottumwa Regional Health Center, has been elected president of the medical staff. **Dr.**

Debra Miller, pediatrician, is immediate past president; **Dr. Mark Leding**, anesthesiologist, is president-elect and **Dr. Kurt Anderson**, otolaryngologist, is secretary. **Dr. Jeffrey Bittner**, obstetrician and gynecologist with Ottumwa Medical Clinic, has become board certified by the American Board of Obstetrics/Gynecology.

Here Comes Doctor Ward: A Climb to Glory

A book about Dubuque general surgeon, Dr. Donovan Ward, is now available from Chicago Spectrum Press. The book, entitled *Here Comes Doctor Ward: A Climb to Glory*, was written by Howard Cartwright (formerly executive director and CEO of the College of American Pathologists) and reviewed by Dr. Marion Alberts, *Iowa Medicine* scientific editor.


The author tells Dr. Ward's extraordinary life story in an interesting way from his childhood through medical practice and on to his AMA presidency.

Dr. Ward has not only given much of his time and talent to the medical profession, but also to various civic organizations. He has worn many hats: banker, navy lieutenant commander, river pilot, talk show host, writer, musician, consultant and entrepreneur.

The author sums up Dr. Ward in this way: "Donovan Ward's life story is a reminder that there are heroes in the cities and towns across America who should be heralded for being role models for everyone whom they meet. This book highlights Dr. Ward's remarkable life, the life of a true American hero."

The narrative is enhanced by numerous sidebar comments by Dr. Ward which makes this book very enjoyable. It is available for \$25 by calling Spectrum Press at 800/594-5190.

Deceased member

Roy Brackin, MD, 93, general surgery/family practice, Oskaloosa, died December 24 .

AT A GLANCE

The IMS domestic violence videotape that was shown at the House of Delegates on Sunday, April 30 is now available on a loan basis. Call Chris McMahon, director of communications, at 800/747-3070 or 515/223-1401 for details.

Dr. Greg Ganske, U.S. Representative and Des Moines plastic surgeon, plans to do charity work at Broadlawns Medical Center. Dr. Ganske has been granted temporary staff privileges at Broadlawns and will volunteer when he's finished with his congressional duties.

Financing of PHYSICIAN VENTURES

As soon as physicians decide which managed care model is the most advantageous, the major obstacle is often securing appropriate financing. The author discusses how to obtain financing for physician-led business ventures and what it takes to be successful in today's marketplace.

The health care marketplace in the United States is changing in ways unimaginable just twenty years ago. Once, managed care was for renegade physicians who believed in unconventional wisdom; today it is becoming a matter of financial survival. For physicians, the debate has shifted from whether a significant portion of Americans will receive care under a managed care system (a foregone conclusion) to what managed care model is the most advantageous.

Physicians are forming many types of ventures, ranging from two independent solo practitioners merging to a large group of physicians developing a health care delivery system employing hundreds of physicians and serving thousands of patients in multiple states. While virtually all organizations can map out some rough goals, strategic objectives and a vision, most of these infant firms will have trouble growing and fulfilling their objectives. Reasons for business failures are usually multiple and may include lack of leadership, management culture

clashes and flawed strategy.

However, most entrepreneurs concur that the most daunting obstacle facing a new business is securing appropriate financing.

Physicians in optimal position

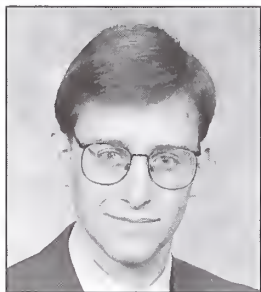
Obtaining financing for a physician-led organization can be troublesome. Many of these corporations are more common than a cold and have many difficulties differentiating themselves in a marketplace over saturated with entities born from a reactive impulse to thwart the managed care movement.

On the bright side, there are millions of dollars waiting in the wings for the "right" managed care development projects and physicians are in an optimal position to tap this pool of money. All indications point to

tremendous interest from private financing companies, existing health systems and the public in funding physician-led ventures.

Most people are aware of the common investment principle that the reward of an investment should be commensurate with the

There are millions of dollars waiting for the "right" managed care development projects.



STEVE DENELSKY
Steve DeNelsky is a senior financial consultant with Medical Alliances in Alexandria, Virginia. He specializes in physician integration, business valuation, mergers and acquisitions. He writes a monthly column in the magazine Group Practice Managed Health Care News.

risk. Unfortunately, rules governing financing are far less lucid. The type of financing an organization employs should depend on current and future investments. In addition, financing methods should always be matched to the firm's particular investment opportunities and not the other way around.

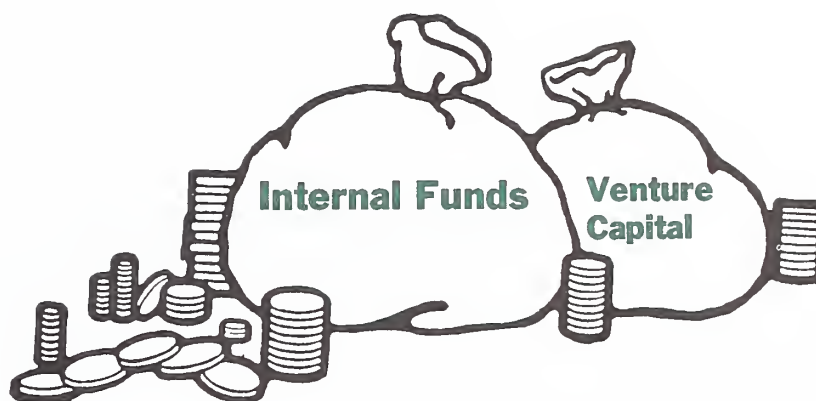
What will the market bear?

Companies face different financing opportunities according to what the market will bear. Different financing is available depending upon variables such as which products or services will be sold, the firm's size and past performance. Especially among smaller entities, the quality of top management can be a factor in determining the spectrum of financing options.

While a plethora of factors shape the financing horizon, they can be whittled down to one all encompassing element — Will the financier receive a fair return on the investment, given the level of risk compared to other opportunities available in the marketplace? Any company trying to locate financing should be able to provide many reasons why the answer to this question is "yes".

Internal funding

Internal funding of investment opportunities is the easiest and quickest method of raising capital. Internal funds, or retained earnings, account for between one half and two thirds of long-term corporate financing.



When a project is earmarked for internal funding, money is simply diverted from the company's cash flow to the investment opportunity. While this type of funding is less expensive, it is by no means "free" financing. If a corporation uses retained earnings to finance an endeavor that loses money, the value of the corporation will decline.

Professional corporations such as independent medical practices usually distribute all earnings to their members on a year-to-year basis. Because of this, these businesses typically do not possess a well of retained earnings to fund new ventures. While funds can be budgeted from the practice towards new projects such as mergers, diversification of capital is tantamount to physicians making an outside investment in their practice, since earnings in that year will decline.

The major advantage of internal funding is that physicians do not have to relinquish control of the business. The disadvantage is that if the project fails, their money will fail also and will never be recouped.

At some point, most companies will find a worthwhile investment opportunity that, due to the required fiscal outlay, cannot be financed through retained earnings. In these situations, a company can look to alternative sources of financing.

continued

The major advantage of internal funding is physicians do not have to give up control of their business.

Joint ventures can also be formed around management expertise, marketing channels or access to primary care physicians.

Strategic alliances and joint ventures

A strategic alliance is a formal relationship between two or more entities arranged to accomplish common goals. A joint venture is similar to a strategic alliance but carries a higher level of legal integration between the parties because a new legal entity is formed.

The impetus behind joint ventures is theoretically very appealing. Each company involved has a strategic advantage in a particular area and they decide to cooperate to achieve common goals.

In many instances, a company will provide or receive some degree of financing through a joint venture. However, joint ventures can also be formed around management expertise, marketing channels or access to primary care physicians.

A strategic alliance or joint venture is an easily-arranged business endeavor; but, for a variety of reasons, most eventually fail. Many physician-led joint ventures fail due to a lack of management expertise. Also, when one party is the key source of money for the venture, the lines may blur between a true "joint" venture and a simple investment. This scenario provides fertile soil for divergent expectations and disagreements on control within the venture.

AMA Capital Funding project

The American Medical Association has recently initiated a program designed to pair physician-led ventures with potential financing sources. The program, Physicians

Capital Source, is intended to let physicians help design health care delivery systems that can compete against insurers and other investor-owned health organizations.

The AMA will help physicians develop business plans and build skills necessary to rival non-physician organizations and secure financing to fuel future growth. In addition, the AMA would like to create an "AMA University" where physicians can attend courses to learn about the fundamentals of managed care and get their business plans reviewed by investors.

(For more information on this new AMA project, see page 206.)

Venture capital and private equity firms

Venture capital or private equity firms are other avenues that can be used to finance a company's investment objectives. Many companies that use venture capital as a financing source may not be able to secure other types of financing because of the company's current financial position. Prime candidates for venture funds are firms which are years away from being able to tap the public equity or debt markets and desire more capital than many traditional private sources, such as banks, would care to risk.

The 2,000 or so venture firms operating in the U.S. provide funds in many different stages of a company's growth—from seed-money to bridge financing. The venture firms usually demand some control in the business that is receiving the financing. In

addition, since venture firms usually invest where their partners have management experience, these firms can provide valuable expertise as well as much needed capital.

Public equity

There has been a proliferation of public stock offerings used to finance companies over the last 10 years. A primary reason for the increased use of the equity markets is that individual investors, largely through the use of mutual funds, have pumped money into stock markets at an unprecedented rate.

While Phycor and Pacific Physician Services may be grabbing headlines for their soaring stock prices, many other health care companies do not have what it takes to attract serious attention from either the public or investment bankers. Most companies need at least \$150 to \$200 million in sales, a predictable growth curve and, most importantly, a management team that can lead the future growth of the company.

Many other financing methods


The methods described account for a large percentage of the dollars raised by health care firms, but just scratch the surface in terms of the number of financing possibilities. The increase in prepaid contracts for medical care should let physician-based groups with steady and predictable revenue streams use the debt markets with more frequency. Nonprofit entities may be able to issue tax-exempt bonds, which basically give

the issuing firm a government subsidy that lowers the total cost of financing. High-yield debt financing is possible for companies with less than stellar credit ratings.

Private placements, preferred stock offerings, convertible bonds and even employee buyouts are all viable means to finance physician-led ventures and shape the health care industry of tomorrow.

Match the financing to the investing

There is no one best way to finance a company. There are many factors that firms should consider when contemplating financing decisions. The size of the firm, cost of capital and current market conditions are all important. Since the money raised from financing activities will ultimately be invested, it is vital for a firm to adequately match the cash flow between financing and investing.

Raising money is an important function of any firm. Choosing a financing method is an integral part of a company's existence and should be done carefully and realistically. While nothing guarantees success in today's turbulent health care marketplace, a company will have a better focus when financing decisions are designed on operational strategies instead of strategies being built around available financing. 

**Private placements,
preferred stock
offerings,
convertible bonds
and employee
buyouts are viable
means to finance
physician-led
ventures.**

AMA's PHYSICIANS CAPITAL SOURCE PROGRAM

"Quality-first" health care delivery

The American Medical Association has created Physicians Capital Source, a program designed to help physicians build and lead "quality-first" health care delivery networks. This new program gives physicians access to managed care, business, financial and legal experts who can help them develop business plans and links them with potential capital sources.

Many physicians lack experience in forming their own health care organizations and networks. Those who are interested and have sound business plans find it difficult to obtain financing. Beginning in 1990, banks, venture capitalists and other investors began to realize the financial viability of physician ventures.

The first step for physicians participating in the Physicians Capital Source Program is the completion of a Request For Information (RFI), which serves as a blueprint for developing a business plan. The program seeks business plans that focus on physician direction in patient care, medical decision-making, allocating resources and policy-making. Plans should also stipulate

that physicians invest in and share the risk in the venture, as well as serve as members of the board of directors.

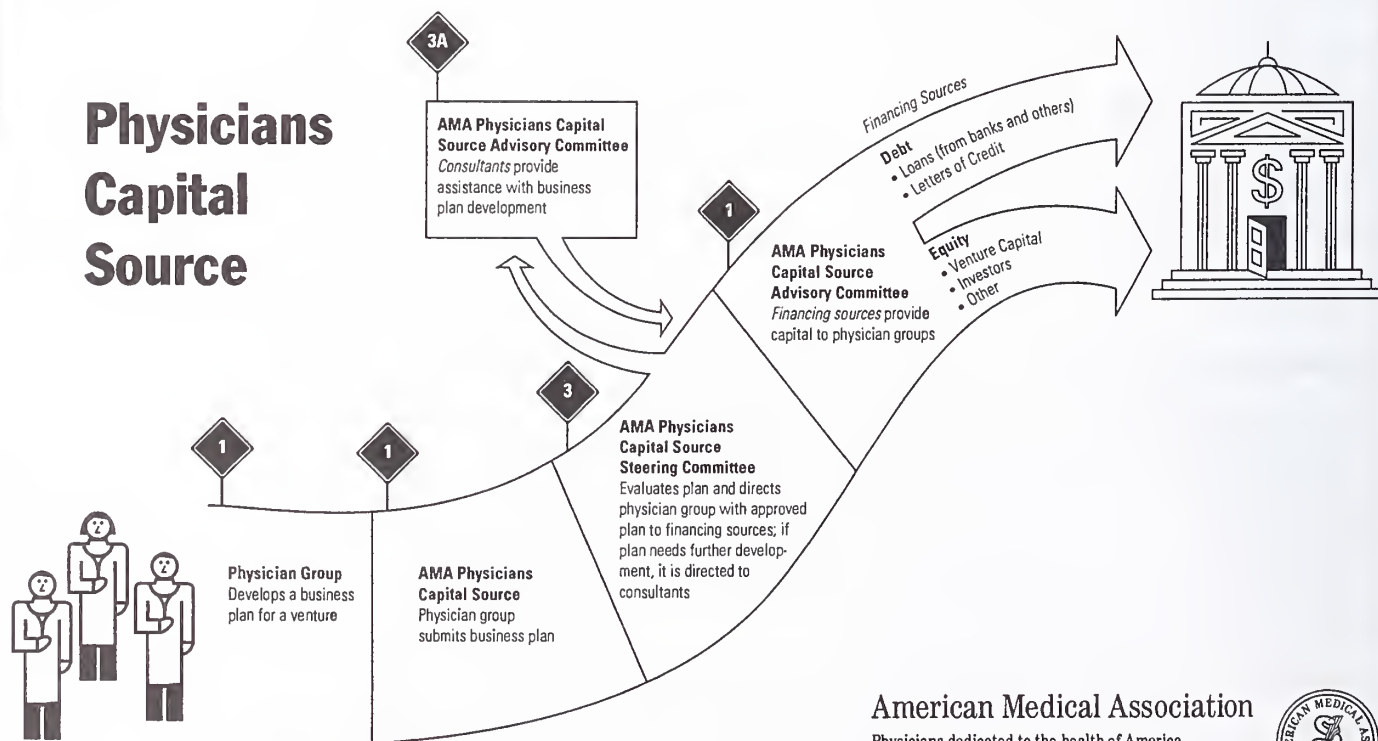
Physicians whose plans are approved are then linked to potential capital sources that can meet their short and long-term financing needs.

Advisory committee

The Physicians Capital Source Advisory Committee is a national panel composed primarily of consultants who develop health care ventures and entities that finance these ventures. Its 61 members also include related health care entities such as Blue Cross plans, medical clinics, a health maintenance organization, foundations and experts in information technology.


Members of the advisory committee offer participants advice and counsel during the application process and evaluate completed business plans to determine if they are viable.

For more information on Physicians Capital Source Program, call the AMA's managed care help line at 800/AMA-1066.



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Physicians dedicated to the health of America






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The Monroe Clinic
A proud caring tradition

Here's to your Health

a patient's guide to better health

The Iowa Medical Society published an information and referral guide for battered partners in the February issue of *Iowa Medicine*. If you would like reprints of this domestic abuse insert, call Jane Nieland or Bev Corron at 800/747-3070 or 223-1401 or send the completed form below to *Iowa Medicine*, 1001 Grand Avenue, West Des Moines, IA 50265. Inserts may be purchased for 15 cents each plus postage. A bill will accompany your insert order.

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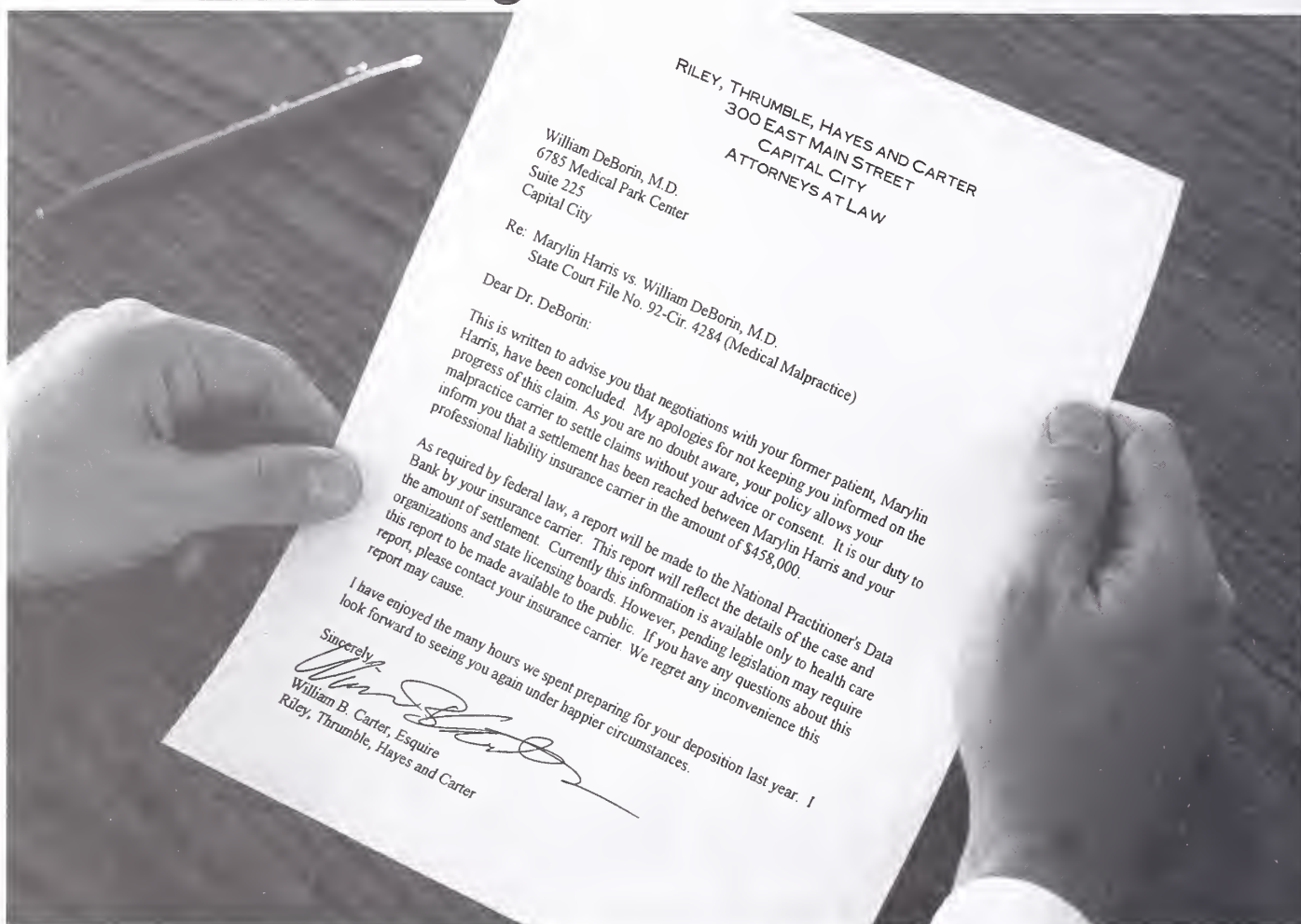
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William DeBorin, M.D.
6785 Medical Park Center
Suite 225
Capital City

Re: Marilyn Harris vs. William DeBorin, M.D.
State Court File No. 92-Cir. 4284 (Medical Malpractice)

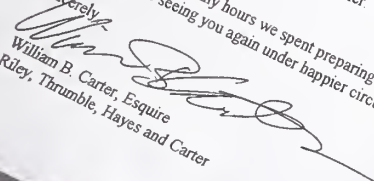
Dear Dr. DeBorin:

This is written to advise you that negotiations with your former patient, Marilyn Harris, have been concluded. My apologies for not keeping you informed on the progress of this claim. As you are no doubt aware, your policy allows your malpractice carrier to settle claims without your advice or consent. It is our duty to inform you that a settlement has been reached between Marilyn Harris and your professional liability insurance carrier in the amount of \$458,000.

As required by federal law, a report will be made to the National Practitioner's Data Bank by your insurance carrier. This report will reflect the details of the case and the amount of settlement. Currently this information is available only to health care organizations and state licensing boards. However, pending legislation may require this report to be made available to the public. If you have any questions about this report, please contact your insurance carrier. We regret any inconvenience this report may cause.

I have enjoyed the many hours we spent preparing for your deposition last year. I look forward to seeing you again under happier circumstances.

Sincerely,


William B. Carter, Esquire
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The Journal

of the Iowa Medical Society

Hepatitis B vaccination: a cost analysis

● GEORGE BERGUS, MD; STEVEN MEIS, MD

In November of 1991 the Centers for Disease Control (CDC) recommended all infants be immunized against hepatitis B. Universal infant immunization promises to eliminate or greatly reduce the incidence of hepatitis B virus (HBV) infection and its sequela of cirrhosis, hepatic cancer and death. The American Academy of Pediatrics and the American Academy of Family Physicians endorsed this recommendation.¹⁻⁵

Despite these endorsements, many physicians have concerns about the wisdom of universal infant HBV immunization.⁶⁻⁹ For some physicians, infant HBV immunization does not have great immediacy because most infections in the U.S. occur after age 15 years. Other physicians feel uncomfortable subjecting infants to yet another series of injections. Negative attitudes are especially common in areas with low risk of infection such as Iowa where the annual attack rate is approximately 2 cases per 10,000 population compared to the national rate of 12 cases per 10,000.^{10,11}

Cost-effectiveness analysis can help physicians decide whether an intervention has sufficient effectiveness at an affordable cost. Most new preventive interventions such as universal HBV immunization do not promise to reduce health care costs but should prolong life at a cost similar to preventive interventions presently in widespread use. Cost-effectiveness studies on the use of hepatitis B vaccination in high incidence populations clearly justify programs to immunize high risk populations.¹²⁻¹⁵

Our study examines the cost-effectiveness of universal HBV immunization using Iowa data and calculates the cost for each year of life saved from implementing a routine vaccination program.

HBV immunizations

Efficacy of the full vaccination series is estimated from randomized and historical clinical trials and is assumed to be 95% for adolescents, 95% for neonates born to HBV negative mothers and 75% for neonates born to HBV positive mothers. Anyone not completing the full three shot vaccination series is considered nonimmunized and susceptible to HBV infection.

Booster immunization against HBV is not included in the model because we assumed that individuals who were successfully immunized had permanent protection from the vaccine. Although antibody titers are known to decrease over time, there is little epidemiologic evidence that these decreases are associated with significantly reduced protection from HBV. Immunized persons who have lost measurable titers of hepatitis B surface antibody might be at risk of infection but in large case series few of these people succumb to infection with jaundice and none have gone on to develop chronic hepatitis.^{16,17}

Costs

For our study, we used the current hepatitis B vaccine cost to our institution, \$26.25 for the three shot infant series and \$86.40 for the adolescent series. We did not include the cost of office visits.

Costs of treating the sequela of HBV infection were taken from a review of the literature and data from medical insurers.¹⁸ Costs are discounted at 5% per year. Discounting years of life remains a controversial issue in cost-effective analysis and are not discounted in most of our analysis.^{19,20} However, for the sake of comparison to some other published studies on preventive interventions, we also calculated

The IMS Education Fund has designated this article as the Henry Albert Scientific Presentation Award for May 1995.

GEORGE BERGUS, MD
Dr. Bergus is with the University of Iowa Department of Family Practice.

STEVEN MEIS, MD
Dr. Meis is a family physician in LeMars.

Hepatitis B vaccination: a cost analysis

continued

the cost-effectiveness of routine infant immunization using discounted years of life.

Results

In Iowa, routine infant immunization against hepatitis B should prevent 48.7 cases of infection per 10,000 newborns saving a total of 52 years of life. The cost per year of life saved is \$2,970 when routine neonatal HBV immunization is added to the current program of screening all pregnancies.

Immunizing all Iowans as teenagers, except individuals born to mothers known to be infected with HBV who will continue to be immunized at birth, will be more costly than immunizing all newborns. Teenage immunization will also be less effective than universal infant immunization in preventing serious hepatitis B sequela because newborns born to unscreened hepatitis B mothers will not be vaccinated. The cost for each year of life saved using teenage immunization is \$11,549. This intervention prevents 32.4 cases of HBV per

10,000 persons saving a total of 21 years of life.

A third possible strategy is to institute infant immunization with a second net to catch nonimmunized children entering junior high. This program has the highest effectiveness but, because of a higher expense than infant immunization alone, the cost per year of life saved rises to \$3,934. This strategy would prevent 58 cases and save 56 years of life per 10,000 persons.

Discussion

Our analysis suggests universal infant immunization is attractive from both clinical and economic perspectives. Routine infant immunization will reduce cases of chronic hepatitis and therefore lost years of life at a cost of \$2,970 per year of life saved. This compares favorably with other widely used preventive health intervention as shown in Tables 1 and 2. Although Iowa and other states with low HBV attack rates pay a higher price for each episode of HBV infection avert-

TABLE 1
COST PER YEAR OF LIFE SAVED FOR SELECTED MEDICAL INTERVENTIONS WITH COSTS DISCOUNTED BUT YEARS OF LIFE NOT DISCOUNTED

<i>Intervention</i>	<i>Cost per year of life saved, \$</i>
Routine infant HBV immunization in Iowa	2,970
Beta-blockers after myocardial infarction	2,700
Pneumococcal vaccine (> 65 years old)	6,000
Cholesterol reduction: oat bran	8,500
: cholestyramine	35,250

Adapted from Bloom B, et al.¹⁶

TABLE 2
COST PER YEAR OF LIFE SAVED FOR SELECTED MEDICAL INTERVENTIONS WITH BOTH COSTS AND YEARS OF LIFE DISCOUNTED

<i>Intervention</i>	<i>Cost per year of life saved, \$</i>
Routine infant HBV immunization in Iowa	41,906
Colon cancer screening at age 65	
annual fecal occult blood test	35,054 ²⁶
adding flex sigmoidoscopy every 3 years	42,892 ²⁹
Breast cancer screening in 55- to 65-year-old women	
:annual breast physical exam	15,536 ²⁷
:annual mammogram with exam	83,830 ³⁰
Hypertension: detection and treatment in 40-year-old males	16,258 ²⁸
INH chemoprophylaxis for recent PPD converter	35,011 ²⁹
Cholesterol reduction using cholestyramine in 55-year-old males	117,400 ³⁰
Tetanus booster every 10 years	146,138 ³¹
Pap smear every year compared to every 2 years in women at average risk of cervical cancer	>1,000,000 ³²

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Why are so many people depressed?

If there be a hell upon earth it is to be found in a melancholy man's heart.

Robert Burton (1577-1640), *Anatomy of Melancholy*

Over 11 million Americans suffer depression (major depressive disorder) each year. Depression affects twice as many women as men. It is known that depression is not caused by any single factor. The exact etiology is not known, but involves biological, genetic, psychological and various life stresses. Why are so many people depressed? We must not be confused by depressed or sad moods that are normal responses to specific life experiences involving loss or disappointment. The major depressive disorder involves far more complex factors. Further, it is necessary to differentiate unipolar and bipolar mood disorders.

Nearly one in eight people may require treatment for depression during their lifetime. The direct costs in the U.S. for treatment combined with indirect costs from lost productivity amounts to about \$16 billion per year in 1980 dollars.

Yet, in spite of these startling figures, experts contend depression is underdiagnosed and undertreated by primary care and other non-psychiatric practitioners. And, these care providers are the ones more likely to see these patients initially.

The Iowa Department of Human Services processed 208,165 Medicaid claims for antidepressants during the period November 1, 1993 through October 31, 1994. These claims

amounted to over \$6.5 million. Prozac® accounted for 29,526 claims totalling \$2,142,102. Other antidepressant drugs accounted for the over 208,000 prescriptions. Antidepressants were second only to cardiac drugs, and Prozac® second to Zantac®.

Comparison of these statistics to general prescribing patterns of antidepressants in Iowa and the U.S. we can assume the cash is enormous. It is striking also, that Zantac® is the most frequently prescribed medication in these reports (49,561 claims paid accounting for cost of \$2,710,192). Depression and ulcers. Which comes first? Why are so many persons affected by these two conditions? We hear the term "stressed out" so frequently. Are these patients facing such insurmountable crises that they

must be sustained with such pharmaceutical agents?

The population of the U.S. is in a sorry state when measured by the prescribing of these two drugs. Is our social status so precarious or have we as mortal beings become unable to cope with the normal routines of our existence?

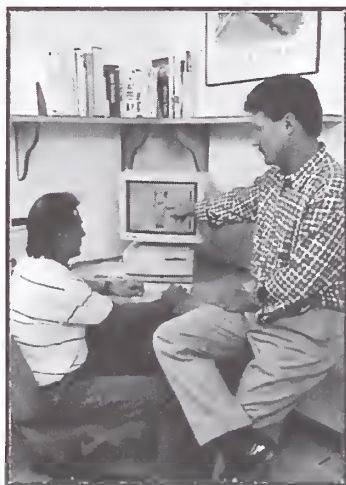
Were the lack of comforts less stressful than our world of complex technology?

Is the world so tumultuous? Were the lack of comforts and the fear of prehistoric monsters less stressful than our world of electronics and complex technology? We can only speculate on these questions. Furthermore I shall not delve into questions on whether antidepressant drugs are injudiciously or over prescribed. That question merits broad discussion and consideration. **IM**



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Reading fast . . . now . . . slow

I used to be a fast reader. Or I thought so, anyway, and the idea was occasionally reinforced by comments from friends. That was

before I started medical school. My slowness in matching the words in Gray's *Anatomy* with the drawings, and correlating both with the actual cadaver took its toll on speed. My physiology text with its complex ideas, hypotheses and murky prose added further deadweight. Then came biochemistry and its lethal definitions, equations and formulations.

Before the end of my freshman year I realized my reading speed lay severely wounded, almost moribund. Even newspaper articles and the comic strip balloons seemed in shock. I felt my eyeballs shifting a syllable at a time and I sensed that my lips moved, too. Being an optimist back then, I assumed these injuries would soon heal and I'd shortly be back to full vigor.

But soon came pathology, microbiology, internal medicine, surgery and then the calamitous flood of print in the form of journal articles and excerpts. Occasionally, with a magazine article or a "light"

short story or novel, I've had a prickles-on-the-neck feeling of flickering improvement. If real help was to arrive, it would need a long convalescence and careful guidance from reading therapists. No rescue has yet occurred.

I suspect I've lots of company in that sad sequence and I feel better imagining an army of fellow sufferers. If there be such, and any are reading this confessional, maybe they (you)

might feel slightly soothed to learn the secret shame is shared. And there's still another reason.

Part of the blame, I feel, for my lamentable situation must lie with the vast numbers of authors I've read. One can't whip through Shakespeare, of course, since Elizabethan English is so different from modern English or modern American. If I'd stuck with Dickens, Hemingway, Arthur Conan Doyle and Earl Stanley Gardner, I'd probably have little to lament. But no, I've read many more authors, and regrettably, most of them produce that misnomer called the biomedical and/or scientific "literature". Another factor has blighted me, perhaps not you: I've needed in my work not only to read but to try to correct or improve

**I felt my
eyeballs shifting
a syllable at
a time and I
sensed that my
lips moved, too.**

a huge number of written items—all sorts of reports, applications, memos, students' papers, items for publication, and so on—some of them, yes, my own. How all that re-writing and copy editing slows one's reading! A wise man once said, "When something can be read without effort, great effort has gone into its writing."

I fear I'm incurable. But in a pitiable effort to light the proverbial match in the darkness, I try, here and there, to improve the quality of others' writing as well as my own. If all that I read were better written, maybe I'd improve, slightly. In any case, I seem hooked on continuing to read; even though slow, my reading of any kind still seems inescapable and brings great joy. **IM**



RICHARD CAPLAN, MD

Classified Advertising

Mankato Clinic, Ltd.—A progressive group practice is seeking additional BE/BC physicians in the following specialties: acute/urgent care, family practice, oncology/hematology, orthopedic surgery and general internal medicine practice. The Mankato Clinic is a 70-doctor multispecialty group practice in south central Minnesota with a trade area population of +250,000. Guaranteed salary first year, incentive thereafter with full range of benefits and liberal time off. For more information, call Roger Greenwald, Executive Vice President, at 507/389-8500 or Byron C. McGregor, Medical Director, at 507/389-8548 or write 1230 East Main Street, P.O. Box 8674, Mankato, Minnesota 56002-8674.

Family Practitioner—McFarland Clinic is actively recruiting a BE/BC family practice physician to assume the responsibilities of an established family medicine practice in central Iowa. Practitioner has support of over 80 medical and surgical sub-specialty physicians in same multispecialty group. Full privileges for a residency-trained family physician at Mary Greeley Medical Center, a 200-bed hospital in Ames, Iowa. Night call on a rotating basis at the Emergency Room at MGMC. McFarland Clinic offers distinct advantages for the practicing physician in providing excellent compensation and benefits, practice management services and a generous retirement program, all in an environment which emphasizes physician cooperation and teamwork. For additional information, call or submit CV to Karen Andersen, 515/239-4535, McFarland Clinic, P.C., 1215 Duff Avenue, Ames, Iowa 50010.

Marshalltown, Iowa

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Beaver Dam, Wisconsin—Medical Associates of Beaver Dam is actively recruiting a BE/BC family physician to join its staff of 6 family physicians. Call is shared equally and all hospital admissions are at our local 100-bed hospital. Beaver Dam is a safe, family-oriented community of 15,000 located 45 minutes north of Madison with excellent schools and 4 season recreational opportunities. Excellent compensation and benefits are provided. For more information please contact Scott M. Lindblom, Medical Staff Recruiter, Dean Medical Center, 1808 West Beltline Highway, 1/800-279-9966, 608/259-5151, fax 608/259-5294 or at home 608/833-7985.

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Springfield, Missouri—Bass Pro Shop and 40 miles to Branson. BE/BC FPs. OB optional, salaried position and production bonus, call 1:7, teaching hospital, university community. Contact Vivian M. Luce, Cejka & Co., 1/800-765-3055 or fax CV for immediate attention to 314/726-3009 (IMs welcome).

Madison, Wisconsin—Dean Medical Center, a 300-physician multispecialty group, is seeking additional family physicians to join its 30-member department. Positions are located at our Arcand Park, East Madison and Deerfield Clinic locations. All positions have an excellent call schedule and obstetrics is optional. Madison is the home of the University of Wisconsin with enrollment of over 40,000 students and the state capital. Abundant cultural and recreational opportunities are available year round. Excellent compensation and benefits are provided with employment leading to shareholder status. For more information contact Scott M. Lindblom, Dean Business Office, 1808 West Beltline Highway, PO Box 9328, Madison, Wisconsin 53715-0328, work at 1/800-279-9966, 608/259-5151 or at home 608/833-7985. An Equal Opportunity Employer.

Janesville, Wisconsin—Dean Medical Center, a 300-physician multispecialty group, is actively recruiting additional BE/BC internal medicine physicians to practice at the Riverview Clinic locations in Janesville, Milton and Delavan, Wisconsin. Traditional internal medicine and urgent care practice opportunities are available. Janesville, population 55,000, is a beautiful, family-oriented community with excellent schools and abundant recreational activities. Excellent compensation and benefits are provided with employment leading to shareholder status. Send CV to Stan Gruhn, MD, Riverview Clinic, PO Box 551, Janesville, Wisconsin 53547 or call 608/755-3500. An Equal Opportunity Employer.

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Janesville, Wisconsin, Urgent Care—Riverview Clinic, a division of Dean Medical Center, is actively recruiting an urgent care physician to join its medical staff. We recently increased our compensation package which is based on a 40-hour work week. Total compensation for Year 1 \$108,000, Year 2 \$134,642 and Year 3 \$135,000. We currently have two physicians which staff the clinic from 9:00 a.m.–9:00 p.m. Monday through Friday and 9:00–11:30 a.m. on Saturday and desire to expand the hours of operation until 9:00 p.m. on Saturday and 1:00–9:00 p.m. on Sunday. Our facility is brand new and well equipped with 8 exam rooms, lab and x-ray. Flexible hours are available with an expected total of 30-40 hours per week. Excellent compensation and benefits are provided. For more information contact Scott M. Lindblom, Dean Medical Center, 1808 West Beltline Highway, Madison, Wisconsin 53713, work phone 1/800-279-9966 or 608/259-5151, fax 608/259-5294, home 608/833-7985.

Laneaster, Wisconsin—Dean Medical Center, a 300+ physician private multispecialty group, is actively recruiting for one board eligible/board certified family physician to practice at the Grant Community Clinic in Laneaster, Wisconsin (population 4,200), an affiliated clinic of Dean Medical Center. Their current staff consists of 3 family physicians and one general surgeon. The group also has 2 physician assistants on staff. Each physician is at the clinic 6 hours a day, 4 days per week, seeing between 20-25 patients daily. A minimum \$110,000 guaranteed salary plus incentive is provided. For more information please contact Scott M. Lindblom, Medical Staff Recruiter, Dean Medical Center, 1808 West Beltline Highway, 1/800-279-9966, 608/259-5151, fax 608/259-5294 or at home 608/833-7985.

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Madison, Wisconsin, Urgent Care—Dean Medical Center a 300+ physician multispecialty group is seeking full time physician to assist in staffing our two urgent care centers. Qualified applicants should be BE/BC in family practice, emergency medicine or internal medicine with experience in pediatrics. Dean Medical Center operates two Urgent Care Centers 365 days per year, from 7:00 a.m.–10:00 p.m. All physicians employed at the urgent care centers are paid on an hourly basis and full time physicians are eligible to go on a shareholder track and buy into the corporation after two years of employment. Excellent compensation and benefits with shareholder eligibility after two years of employment. For more information contact Scott M. Lindblom, Dean Medical Center, 1808 W. Beltline Highway, PO Box 9328, Madison, Wisconsin 53715-0328, at work 1/800-279-9966 or 608/259-5151 or home 608/833-7985.

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Orange City, Iowa

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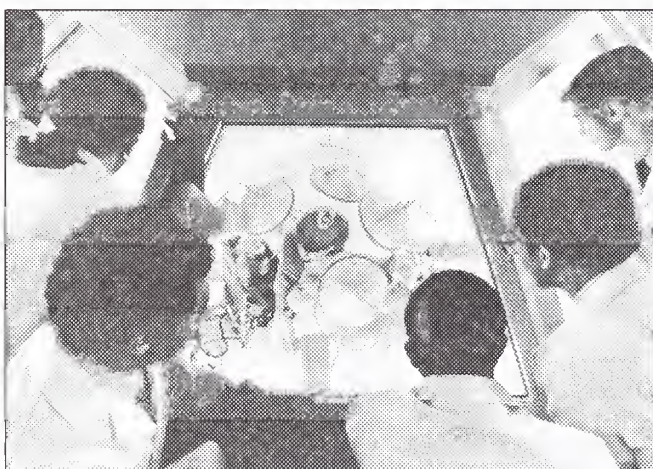
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Electrodiagnostic Medicine*

Emergency Medicine

Acute Care, Inc.
P.O. Box 515
Ankeny 50021
515/964-2772 or 1-800/729-7813
*Comprehensive Emergency Medicine
Practice, Locum Tenens,
Doctor on Call*

Emergency Practice Associates
P.O. Box 1260
Waterloo 50704
1-800/458-5003
*Specialists in Emergency
Staffing & Emergency Department Services*

Family Practice

Acute Care, Inc.
P.O. Box 515
Ankeny 50021
515/964-2772 or 1-800/729-7813
*Locum Tenens
Doctor on Call*

Infectious Diseases

**Chest, Infectious Diseases & Critical Care
Associates, PC**
Daniel H. Gervich, MD
Daniel J. Schroeder, MD
Ravi K. Vemuri, MD
Infectious Diseases
1601 NW 114th, Suite 347
Des Moines 50325-7072
24 hours 515/224-1777

Infertility

Mid-Iowa Fertility, PC
Donald C. Young, DO
3408 Woodland Avenue, Suite 302
West Des Moines 50266
515/222-3060
*Reproductive Endocrinology/Infertility
IVF and GIFT Procedures
Donor Oocyte Program
Artificial Inseminations
Reproductive Surgery
Menopause Management*

Internal Medicine

Fort Dodge Medical Center, PC
Cardiology
Samir G. Artoul, MD, FICC
515/574-6840
Gastroenterology
Kenneth W. Adams, DO, AOBIM
General Internal Medicine
William C. Robb, MD
Richard H. Brandt, MD, ABIM
Grace Z. Ang, MD
800 Kenyon Road
Fort Dodge 50501
515/574-6820

Neurology

Iowa Medical Clinic Neurology
Andrew C. Peterson, MD
Laurence S. Krain, MD
600 7th Street SE
Cedar Rapids 52401
319/398-1721
*Neurology, EEG, EMG, Evoked Potentials
and Sleep Studies*

Fort Dodge Medical Center, PC
Jugal T. Raval, MD, MBBS
800 Kenyon Road
Fort Dodge 50501
515/574-6845

Neurosurgery

**Iowa Medical Clinic
Neurosurgery**
James R. Lamorgese, MD
600 7th Street, SE
Cedar Rapids 52401
319/366-0481
Practice limited to Neurosurgery

Hosung Chung, MD
2710 St. Francis Drive, Suite 401
Waterloo 50702
319/232-8756; fax 319/232-5703
Practice limited to Neurosurgery

Neurosurgical Services LLP

Robert Hayne, MD
Thomas A. Carlstrom, MD
David J. Boarini, MD
 1215 Pleasant, Suite 608
 Des Moines 50309
 515/241-5760

Robert C. Jones, MD
S. Randy Winston, MD
Douglas R. Koontz, MD
 2600 Grand Avenue, Suite 210
 Des Moines 50312
 515/283-2217
Neurological Surgery

Chad D. Abernathy, MD
 1953 1st Avenue SE
 Cedar Rapids 52402
 319/363-4622
Neurological Surgery

Obstetrics/Gynecology

Fort Dodge Medical Center, PC
Brian L. Welch, MD
 800 Kenyon Road
 Fort Dodge 50501
 515/574-6870

Ophthalmology

Wolfe Clinic, PC
Russell H. Watt, MD
John M. Graether, MD
Gilbert W. Harris, MD
James A. Davison, MD
Norman F. Woodlief, MD
Eric W. Bligard, MD
David D. Saggau, MD
Steven C. Johnson, MD
Todd W. Gothard, MD
 309 East Church
 Marshalltown 50158
 515/754-6200

Satellite Offices
 Lakeview Medical Park
 6000 University Avenue, Suite 300
 West Des Moines 50266
 515/223-8685

804 South Kenyon Road, Suite 100
 Fort Dodge 50501
 515/576-7777

Sartori Professional Building
 516 South Division Street
 Cedar Falls 50613
 319/277-0103

214 - 13th Street Southeast
 Cedar Rapids 52403
 319/362-8032

Ophthalmic Associates, PC
Robert D. Whinery, MD
Stephen H. Wolken, MD
Robert B. Goffstein, MD
Lyse S. Strnad, MD
 540 E. Jefferson, Suite 201
 Iowa City 52245
 319/338-3623

North Iowa Eye Clinic, PC
Addison W. Brown, Jr., MD
Michael L. Long, MD
Bradley L. Isaak, MD
Randall S. Brenton, MD
James L. Dummert, MD
 3121 4th Street, S.W.
 P.O. Box 1877
 Mason City 50401
 515/423-8861

Timothy F. Moran, Jr., MD
 United Federal Building
 700 4th Street, Suite 305
 Sioux City 51101
 712/252-4333

Satellite Clinics
 Horn Memorial Hospital
 700 E. 2nd Street
 Ida Grove 51445
 712/364-3311

Orange City Hospital
 400 Central Avenue NW
 Orange City 51041
 712/737-2426
General Ophthalmology

Orthopaedics

Iowa Orthopaedic Center, PC
Marvin H. Dubansky, MD
Marshall Flapan, MD
Sinesio Misol, MD
Joshua D. Kimelman, DO
Timothy G. Kenney, MD
Lynn M. Lindaman, MD
Jeffrey M. Farber, MD
Kyle S. Galles, MD
Scott A. Meyer, MD
Cassim M. Igram, MD
Donna J. Bahls, MD
Jill R. Meilahn, DO
Jacqueline M. Stoken, DO
 411 Laurel, Suite 3300
 Des Moines 50314
 515/247-8400

Orthopaedic Surgery

Fort Dodge Medical Center, PC
C. Mark Race, MD
 800 Kenyon Road
 Fort Dodge 50501
 515/574-6880

Otolaryngology

Iowa ENT, PC
Thomas A. Ericsen, MD
Marshall C. Greiman, MD
Steven R. Herwig, DO
Thomas O. Paulson, MD
Mark K. Zlab, MD
 1-800/248-4443
 1215 Pleasant, Suite 408
 Des Moines 50309
 515/241-5780

1200 35th Street, Suite 200
 West Des Moines 50266
 515/225-7761
Satellite Clinics:

*Pella, Perry, Newton, Indianola,
 Oskaloosa, Guthrie Center, Knoxville*

Wolfe Clinic, PC
Michael W. Hill, MD
Daniel J. Blum, MD
 309 East Church
 Marshalltown 50158
 515/752-1566

Lakeview Medical Park
 6000 University Avenue, Suite 310
 West Des Moines 50266
 515/224-9533

Sartori Professional Building
 516 South Division Street
 Cedar Falls 50613
 319/277-3105

*Otolaryngology-Head and Neck Surgery,
 Facial Plastic Surgery, Allergy*

Phillip A. Linquist, DO, PC
 1000 Illinois
 Des Moines 50314
 515/244-5225

*Ear, Nose and Throat Surgery,
 Facial Plastic Surgery, Head
 and Neck Surgery*

(Continued next page)

Professional Listing Rates

Physician members of the Iowa Medical Society may advertise in this directory. Monthly rates are as follows: \$10.00 first 3 lines; \$2.00 each additional line. Billed yearly. May be prorated. Send or fax copy to Iowa Medical Society, 1001 Grand Avenue, West Des Moines, Iowa 50265-3599, fax 515/223-8420.

Iowa Head and Neck Associates, PC

Robert T. Brown, MD
Eugene Peterson, MD
Richard B. Merriek, MD
Peter V. Boesen, MD
Robert R. Updegraff, MD
 3901 Ingersoll
 Des Moines 50312
 515/274-9135

Dubuque Otolaryngology-Head & Neck Surgery, PC

Thomas J. Benda, Sr., MD
James W. White, MD
Craig C. Herther, MD
Thomas J. Benda, Jr., MD
 310 North Grandview Avenue
 Dubuque 52001
 319/588-0506

Otologic Medical Services, PC

Roger A. Simpson, MD
Guy E. McFarland, MD
Thomas F. Viner, MD
Douglas E. Dawson, MD
 540 E. Jefferson, Suite 401
 Iowa City 52245
 319/351-5680
 1-800/642-6217
Maxillofacial, Plastic, Head & Neck Surgery

Robert G. Smits, MD, PC

1040 5th Avenue
 Des Moines 50314
 515/244-8152
 1-800/622-0002
*Ear, Nose and Throat Surgery,
 Facial Plastic Surgery and Head and Neck Surgery*

Pain Management**Iowa Medical Clinic Outpatient Pain Treatment Center**

James R. LaMorgese, MD, FACS,
Neurosurgeon, Medical Director
Sandra Gannon, LSW, ACSW, Program Director
 600 7th Street SE
 Cedar Rapids 52401
 319/399-2013
*Neurology, Psychiatry, Anesthesiology,
 Rheumatology*

Perinatology**Des Moines Perinatal Center, PC**

Neil T. Mandsager, MD
 3408 Woodland Avenue, Suite 302
 West Des Moines 50266
 515/222-3060
*Maternal-Fetal Medicine
 Routine and Advanced (Level II)
 Obstetric Ultrasound
 Genetic Counseling
 Amniocentesis and CVS
 Antenatal Testing
 High-Risk Obstetrical Management
 High-Risk Deliveries*

Physical Medicine & Rehabilitation**Genesis Regional Rehabilitation Center**

Genesis Medical Center
 1227 East Rusholme Street
 Davenport 52803
 319/383-1466
Maurice D. Schnell, MD
Fareeduddin Ahmed, MD
Arthur B. Searle, MD
Bogdan E. Krysztofiak, MD

Rehabilitation Medicine Associates

William D. deGravelles, Jr., MD
Charles F. Denhart, MD
Marvin M. Hurd, MD
William C. Koenig, Jr., MD
Karen Kienker, MD
Todd C. Troll, MD
Lori A. Sapp, MD
Yunker Rehabilitation Center
Iowa Methodist Medical Center
 1200 Pleasant
 Des Moines 50308
 515/241-6434

2600 Grand Avenue, Suite 102
 Des Moines 50312
 515/283-1570

Pulmonary Medicine**Fort Dodge Medical Center, PC**

Robert C. Ang, MD, FCCP
 800 Kenyon Road
 Fort Dodge 50501
 515/574-6820

Chest, Infectious Diseases & Critical Care Associates, PC

Roger T. Liu, MD
Steven G. Berry, MD
Donald L. Burrows, MD
Michael Witte, DO
Gerard A. Matysik, DO
 1601 NW 114th, Suite 347
 Des Moines 50325-7072
 24 Hour 515/224-1777
Pulmonary Diseases

Surgery**Wendell Downing, MD**

1212 Pleasant Street, Suite 410
 Des Moines 50309
 515/241-5767
Diseases and Surgery of the Colon and Rectum

Fort Dodge Medical Center, PC

Ralph E. Woodard, MD, FACS
Dan P. Warlick, MD, FACS
 800 Kenyon Road
 Fort Dodge 50501
 515/574-6865

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Why we need to organize

This is my first column as your IMS president and I'd like to use this opportunity each month to keep in touch with you on the issues I find most relevant to the practice of medicine today.

Although the obvious pressure for health system reform in Washington is less evident, limited health system reform remains alive in Congress and will undoubtedly occur. Reform is occurring in the private sector at an unprecedented rate. While no one knows exactly what these changes will bring, there are some things which are evident such as the formation of hospital networks or systems like the Iowa Healthcare System which involves hospitals in Des Moines and Cedar Rapids plus various smaller outlying hospitals.

Physicians also must organize, though this is not news to anybody. For the past few years, the IMS has promoted education in how to form physician organizations. Physicians have been encouraged to form POs so they may better deal with their local hospital and the emerging major networks.

One of the problems we face when POs are established is surrender of autonomy. When you organize, you give up some of your autonomy. It also means trusting your colleagues. Choose good people and then let them do their job.

Another factor which is a real change for most physicians relates to the assumption of


financial risk in the various health care provider organizations. As in all spheres of economics, risk is related to return. We as physicians should be willing, through our organizations, to assume risk.

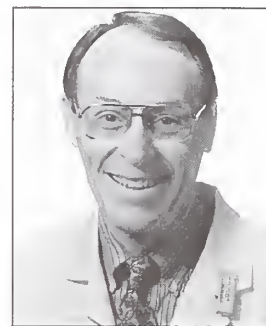
Another very good reason for physicians to be organized is the potential for an abrupt change in patient referral and care patterns that can occur with managed care. Instead of a slow trickle of patients going to another health care source, the change comes about much more dramatically. Iowa may be a little different because of our large number of rural physicians and rural population. However, 80% of Iowa doctors are in 16 counties. Those that are in rural areas may have a factor of insulation those in larger cities do not enjoy.

**Physicians
should
be willing,
through our
organizations,
to assume risk.**

In the future, POs may be affiliated with various health care delivery systems and the IMS will become a logical way for these physicians to advocate patients when problems arise. The IMS has always assumed this role but the degree of involvement could become greater.

This year will see the continued evolution of POs and health care delivery systems and interfacing of these organizations and networks. There will be other important issues such as CHMIS and the IMS campaign against violence.

I encourage you to be involved so you can influence your fate and the fate of medicine. Above all, we must always make sure patient care is our number one primary concern. 



JOSEPH HALL, MD

IMS Update

AT A GLANCE

The American Medical Association has begun the process to select a successor for James Todd, MD, who announced he is retiring as AMA executive vice president in June, 1996. Five AMA board members have been appointed to a search committee. They are: Frank Walker, MD of Michigan (chair); Yank Coble, Jr., MD, Florida; Richard Corlin, MD, California; Nancy Dickey, MD, Texas; Robert McAfee, MD, AMA president.

David Bickham, executive director of the Oklahoma Medical Association, has sent a special message to everyone in the organized medicine federation who contacted the OMA regarding the bombing in Oklahoma City. "The outpouring of support from our members was astonishing and gratifying," Bickham said. "Many physicians closed their offices and reported to hospital emergency rooms in the proximity of the disaster."

IMS elects physician officers

Joseph Hall, MD, a Des Moines radiologist, was installed as president of the Iowa Medical Society on Sunday, April 30. The installation ceremony concluded the Society's three-day House of Delegates and Scientific Session at the Marriott Hotel.

Other physicians elected to office are:

President-elect (1-year term) — William McMillan, MD, Ottumwa.

Vice-president (1-year term) — Sterling Laaveg, MD, Mason City.

Trustee (3-year term) — Siroos Shirazi, MD, Iowa City.

Speaker, House of Delegates (1-year term) — Donald Kahle, MD, Dubuque.

Vice speaker, House of Delegates (1-year term) — Tom Throekmorton, MD, Spencer.

AMA delegates (2-year terms) — Clarkson Kelly, Jr., MD, Charles City; Daniel Youngblade, MD, Sioux City.

AMA alternate delegates (2-year terms) — Bernard Fallon, MD, Iowa City; Bryan Peehous, MD, Dubuque.

Councilor, District I — Robert Kent, MD, Burlington; District VI — John Justin, MD, Mason City; District IX — Jay Heitzman, MD, Ottumwa; District XIII — Linda Iler, MD, Lake City.

In addition, Harold Miller, MD, Davenport, was elected chairman of the IMS Board of Trustees and John Brinkman, MD of Mason City was elected secretary-treasurer.

More about the president-elect

William McMillan, MD, an Ottumwa otolaryngologist, was elected president-elect of the Iowa Medical Society on Sunday, April 30. Dr. McMillan graduated from the University of Michigan Medical School and served a residency at the University of Iowa.

He has served on numerous IMS committees and as a delegate. He will take office in April of 1996.

IMS domestic violence video complete

The Iowa Medical Society's videotape "Break the Silence; Begin the Cure" on domestic violence is complete and available for loan to any Iowa physician. The videotape is 27 minutes long, contains Iowa experts and is aimed at educating Iowa physicians on how to manage victims of domestic abuse. The tape was a project of the IMS Task Force on Domestic Violence.

Any physician wishing to borrow the videotape should call Chris McMahon, IMS director of communications, at 515/223-1401 or 800/747-3070. The tape can also be purchased for \$20.

SPECIALTY SOCIETY UPDATE

Nearly 300 clinic managers and 120 exhibitors attended the IMGMA Spring Meeting May 3-5 at the Des Moines Marriott. This was the largest meeting ever held by IMGMA.

Dr. Jeffrey Watters is the newly-elected president of the Iowa Academy of Otolaryngology. Dr. Martin Shularik is president-elect and Dr. Timothy Grissom is secretary-treasurer.

Twenty-three physicians attended a recent meeting of the American Medical Directors Association, Iowa Chapter. Dr. Robert Bender and Dr. Stanley Haugland gave presentations on managing acutely ill patients in nursing homes and quality of life for the elderly.

Over 75 anesthesiologists attended the Iowa Society of Anesthesiology Anesthesia Update meeting in early April in Des Moines. Dr. Norig Ellison, president-elect of the American Society of Anesthesiologists, was the guest luncheon speaker.

Members of the Iowa Association of County Medical Examiners discussed DCI lab usage at a recent meeting held at IMS headquarters.

The transition to Medco Behavioral Health operating the Medicaid mental health benefit for the state of Iowa continues to cause concern for Iowa psychiatrists. The time necessary to obtain approvals for inpatient services has caused delays and contracts sent to Iowa psychiatrists have been problem areas. The Iowa Psychiatric Society has appointed a Medco Task Force which meets about every two weeks.

FOCUS ON IMS ALLIANCE

A recent survey indicated the top concern for the Alliance is membership growth and retention. The AMA Alliance has developed a plan to promote Family Violence Prevention as our first national health promotion project. All counties and states are urged to participate in SAVE: Stop America's Violence Everywhere.

A SAVE violence-free day will be held on October 11, 1995. We will hear more about this program during our IMSA Summer Board meeting July 19-20 in West Des Moines.

The joint IMS/IMSA mini-internship program is

again one of our priorities. During the past five years, over one-third of all Iowa legislators have participated in this program. This year, we are expanding the program to include congressional representatives.

Don't forget that the AMA-ERF funds are more desperately needed than ever. As the federal government decreases loans for students, we must pick up the slack. Fifty percent of those who quit medical school do so because of lack of funds.

I am pleased to serve as 1995-96 IMSA president. I urge all spouses to get involved and make a difference!

Contributed by Linda Miller, president, IMSA

IMS physician award winners

The 1995 IMS Merit Award was given to Laverne Wintermeyer, MD, Des Moines, Saturday evening, April 29 at the IMS Annual Banquet at the Marriott Hotel.

Dr. Wintermeyer is the state epidemiologist and received the award for his work as an effective liaison between Iowa physicians and the Iowa Department of Public Health, from which he retired last October. He has served on an IMS Task Force on AIDS.

Dr. Herman Hein, Iowa City, received the Ben T. Whitaker Award of the Interstate Postgraduate Medical Association of North America. Dr. Hein is a professor of pediatrics at the University of Iowa College of Medicine and is credited with starting the statewide perinatal program in Iowa.

Dr. Paul Laube, surgeon from Dubuque, received the Iowa Medical Society's Physician Community Service Award. Dr. Laube's civic activities include serving on the University of Dubuque Board of Directors and Dubuque Rotary Club. He has been director of the Bethany Home, a local retirement center.

IMS honors lay individuals

The John H. Sanford Award was given to Jim Koch, longtime executive secretary of the Rock Island and Scott County Medical Societies. Mr. Koch retired May 1 after 25 years of service to the medical profession. This award honors lay individuals for contributions to the medical profession.

Mary Ann Bechler, clinic administrator for the Northwest Iowa Orthopaedic and Sports Center in Sioux City received the IMS Outstanding Office Administrator Award at the IMS Annual Banquet Saturday evening, April 29. Ms. Bechler works with four physicians and 25 employees and has been active

in both professional and civic organizations at the state and local levels.

Members of the IMS Alliance were recipients of the Washington Freeman Peck Award for their contribution to the health care field and for efforts in educating physicians and the public about domestic violence.

Notice from Iowa BME

The Iowa Board of Medical Examiners (BME) is recruiting Iowa physicians to serve on its peer review committees. Licensed physicians board certified in anesthesiology, emergency medicine, internal medicine, family practice, obstetrics/gynecology, surgery or psychiatry are strongly urged to apply.

Peer review committees in each specialty evaluate quality of care cases and report findings and recommendations to the Board. When conducting peer reviews for the Board, committee members are under contract with the state and, as such, are granted immunity from civil liability under law. Peer reviewers receive nominal payment for their services and compensation for most expenses.

For additional information, on serving as a peer reviewer, contact Ann Martino, executive director of the BME, at 515/281-5171.

New project to help stop teen pregnancy

Members of the newly-formed Mahaska County Medical Society Alliance have embarked on a new project to help stop teenage pregnancy. The Alliance is raising money for purchase of "Baby, Think it Over" dolls to donate to area schools.

The dolls cry and do not stop until the doll is picked up and a feeding plug inserted. The Alliance hopes to purchase 10 of the dolls for Oskaloosa High School. For more information, call Karen Messamer, 515/673-5165. **IM**

Futures

AT A GLANCE

At its recent House of Delegates, the Iowa Hospital Association decided to change its name to Association of Iowa Hospitals and Health Systems. The official name change will occur sometime this summer.

The Sacramento Medical Society is putting heat on an HMO that recently terminated 100 area specialists without cause. The SMS placed an open letter in the local paper expressing the opinion that the terminations were done without concern for patients.

ABC News is preparing a series of Tim Johnson reports on managed care issues. Dr. Nancy Dickey, AMA trustee, will be interviewed for the series. As of press time, air dates were not yet determined.

Capitation: a physician's guide

Later this summer, the AMA will publish a new book entitled *Capitation: A Physician's Guide*. The book is expected to be available July 30.

The book is written to help physicians understand what capitation is and how it may affect your practice. To really prepare for capitation, says the AMA, you need to learn about it now. The book will help you evaluate capitation agreements and rates and tell you how to thrive under capitation.

For more information on purchasing the book, call the AMA at 800/621-8336.

Emphasis on board certification

The requirement of board certification as the primary qualification for a physician contracting with managed care plans is growing. A recent article in the *Internist*, a publication of the American Society of Internal Medicine, questions whether board certification should be the only requirement considered.

"The public accepts certification as a reliable measure of quality, but both physicians and health plans are asking, 'Is this really a valid measure?'," writes Lee Newcomer, MD, medical director of United HealthCare.

Though board certification is a worthy measure of achievement, the article said, other factors such as patient satisfaction, a physician's ethical nature and clinical judgment should be considered.

Medicare battle heating up

Amid predictions that the Medicare fund will go broke in less than 10 years, lawmakers are struggling to find ways to curb spending without incurring the wrath of groups such as the American Association of Retired Persons.

The AMA and others have begun discussing income-based premiums for well-off Medicare recipients; AARP vows to fight any such pro-

posals and is calling for cuts in other parts of the federal budget to fund Medicare.

President Clinton, in a speech at the White House Conference on Aging, vowed to defend Medicare against budget-cutting Republicans in Congress. According to the AMA, the White House declined a GOP invitation to propose ways to restructure Medicare.

Republican leaders in Congress say they'll defer proposals to restructure Medicare for at least several months so the politically explosive question of health care for the elderly will not become entangled in Congressional efforts to slash the federal budget deficit.

Both the President and Republicans are apparently assuming that whoever first specifies cuts in Medicare will suffer severe political damage, reports the AMA.


Patient rights, responsibilities

The National Health Council has endorsed a statement listing patients' rights and responsibilities in the new health care environment. The statement has been enthusiastically endorsed by the AMA:

All patients have the right to:

1. Informed consent in treatment decisions, timely access to specialty care and confidentiality protections.
2. Concise and easily understood information about their coverage.
3. Information on how coverage payment decisions are made and how they can be fairly appealed.
4. Complete information about the costs of their coverage and care.
5. A reasonable choice of providers and information about provider options.
6. Information about provider incentives or restrictions that might influence practice patterns.

All patients have a responsibility to:

1. Live healthy lifestyles.
2. Become knowledgeable about their health plans.
3. Participate actively in decisions about their health care.
4. Cooperate fully on mutually accepted courses of treatment. 



CHMIS *Update*

As part of the Iowa Medical Society's ongoing effort to educate Iowa physicians about the Community Health Management Information System (CHMIS), this CHMIS Update page will be a regular feature in *Iowa Medicine*.

IMS CHMIS COMMITTEE

The Iowa Medical Society's Ad Hoc Committee on CHMIS held a lengthy meeting on April 4 to discuss issues of patient confidentiality, use of the CHMIS data base, costs of operating the system and the governance and mission of CHMIS.

The committee approved an IMS statement of policy on CHMIS. (The policy statement was subsequently approved by the 1995 IMS House of Delegates and is reprinted on pages 243 and 244 of this *Iowa Medicine*.)

The committee asked the IMS Board of Trustees to consider joining with the Iowa Hospital Association or other partners to become joint administrators of the CHMIS data repository, recognizing that the CHMIS Governing Board still has control of the repository. The IMS Board is now exploring the committee's proposal.

CHMIS GOVERNING BOARD

The CHMIS Governing Board met in March and selected a consultant to work with the Technical Advisory Committee to develop a Request For Proposal (RFP) for the data repository. The Board is expected to release the RFP after its August meeting.

An updated report was given on the six other Hartford-funded CHMIS projects around the country. None are continuing in the community-mission, consensus-driven process Iowa is following.

CHMIS ADVISORY COMMITTEE ACTIVITIES

(IMS staff are observers at all advisory committee meetings and work groups.)

•Ethics and Confidentiality

This advisory committee continues to develop broad guidelines for appropriate users and uses of data in the CHMIS repository. They have drafted a statement regarding educating the consumer public on data collection through CHMIS.

•Education and Communication

This advisory committee is developing a proposed "Questions and Answers" brochure about CHMIS.

•Technical Advisory

This advisory committee has divided into two work groups — one is focusing on the RFP for the data repository and one on the certification process for networks. The RFP group is meeting with the consultant to begin writing the RFP.

The network work group has recommended using the criteria developed by the Electronic Health Care Accreditation Commission (EHNAC) as the framework for Iowa network certification criteria. They are making final modifications to tighten the criteria.

•Data Advisory

This Advisory Committee has made a recommendation regarding what data elements should be collected for the CHMIS repository from the UB-92 forms, HCFA-1500 forms and from payers. This includes payment and charge data. The recommended list of data elements has been forwarded to the CHMIS Governing Board.

The committee has begun work on a patient satisfaction tool for use in CHMIS Phase 1, and pharmacy claim data elements to be collected by the data repository.

•Quality Review

This committee continues to review definitions and protocols for collecting the data elements proposed by the Data Advisory Committee. Those elements — without clear definition or with variety in protocol — are being identified for clarification and standardization.

Look on page 242 of this issue for more information on CHMIS!

YOUR representatives on state CHMIS committees:

CHMIS Governing Board:

Dale Andringa, MD
Des Moines
515/241-4102

Beth Bruening, MD
Sioux City
712/233-1529

CHMIS advisory committees:

Communications / Education

Laine Dvorak, MD
Thomas Evans, MD

Data Advisory

William Bonney, MD
John Brinkman, MD

Ethics/Confidentiality

Charles Jons, MD

Quality Review

Elie Saikaly, MD
William Langley, MD

Technical Advisory

Thomas Menzel, MD
Mark Purtle, MD

IMS CHMIS Committee:

Terrence Briggs, MD (chair)

IMS staff:
Barb Heck
Ed Whitver

Legislative Affairs

AT A GLANCE

As of press time, and in spite of the Senate vote to kill the Kyl amendment capping noneconomic damages in medical liability cases, the issue is not dead. Because the House passed a bill which includes a cap, the issue remains alive for conference committee discussion. In last week's vote, Senator Charles Grassley voted not to kill the cap; Senator Harkin voted to kill it. All IMS member physicians are urged to write to Senator Grassley and thank him for his vote.

The Virginia Legislature has sent the governor a bill that would give physicians and patients the right to request an external review of a utilization review decision.

Review of bills in Iowa Legislature

The legislature adjourned its 1995 session on May 4. Following is a review of bills of potential interest to Iowa physicians. There are many more bills that were introduced this year although most did not go anywhere. For more information on these issues or on issues not covered, please contact Becky Roorda or Paul Bishop at the IMS.

Liability Reform

The IMS was successful in gaining passage of a reduction in the statute of limitation for minors by the Iowa House of Representatives, receiving support from both Republicans and Democrats. However, the bill has not passed in the Senate and was assigned to the traditionally unsupportive Judiciary Committee. HF 394 remains alive for 1996. Physicians are encouraged to work with local state senators over the summer and fall to let them know how important it is to you and your patients.

Any Willing Provider

Several versions of any willing provider bills were introduced but were not successful. A "direct access to chiropractors" amendment was adopted by the Senate in the last weeks of the session. The House refused to adopt the Senate language in spite of heavy lobbying by chiropractors. We expect to see this issue again in 1996.

Definition of surgery — SF 348

The IMS bill establishing a definition of surgery failed to meet critical legislative deadlines and did not pass. It was approved by the Senate Human Resources Committee but was referred to the State Government where it died for the year.

Uniform Anatomical Gift Act — SF 117

The IMS worked with the Iowa Statewide Organ Procurement Organization, the Iowa

Hospital Association and the Iowa State Bar Association to update and improve Iowa's organ donation laws. The new law makes several changes including allowing teenagers to sign a document of gift with the cosignature of a parent and legally recognizing the checkmark on our driver's licenses as a document of gift. The July issue of *Iowa Medicine* will contain more detailed information.

Trauma System — SF 118

The IMS supported SF 118 establishing a statewide trauma system to ensure that all components of Iowa's trauma system are coordinated. The plan includes a system for voluntary verification of trauma capabilities. Many IMS member physicians were involved in the development of the plan.

Volunteer Physician Program — HF 197

The program initiated by the Iowa Medical Society to provide state indemnification for physicians who provide free medical care to needy Iowans will be expanded to include nurses and physician assistants beginning July 1. Physicians and other practitioners must receive specific approval for such protection by the state. For an application packet, contact Cheryl Christie, Volunteer Physician Program, Iowa Department of Public Health, Lucas State Office Building, Des Moines, IA 50319.

Board of Medical Examiners Impaired Physician Program — SF 346

The IMS supported a successful initiative by the Board of Medical Examiners to provide confidentiality protection for mentally or physically impaired physicians who voluntarily report themselves to the Board of Medical Examiners. Physicians who self report and agree to cooperate with the Board in a treatment program will be protected from public disclosure through the state's peer review confidentiality laws.

Drug Testing of Babies — SF 150

Laboratory tests to detect the presence of

illegal drugs in infants and children performed under state child in need of assistance laws will have to meet criteria to be established by the Iowa Department of Public Health, according to SF 150. The requirement is intended to ensure that drug tests are accurate and the presence of drugs in the child's system is confirmed before the test results are used to remove a child from the parent's home.

Medicaid

SF 462, the Medicaid appropriations bill, expands the prior authorization program for Medicaid to include brand name drugs for which there is an "A" rated generic bioequivalent (no prior authorization for use of the generic) beginning September 1. It also provides detailed instructions for a study of the cost effectiveness of the Medicaid prior authorization program and eliminates prior authorization for Clozaril.

However, the bill does not prevent the Medicaid program from continuing to implement strict criteria for payment for Clozaril (clozapine). Existing Medicaid criteria closely follow the restrictions placed on use of the drug by its manufacturer Sandoz Pharmaceuticals.

SF 462 also funds for a 5% increase in reimbursement for obstetrical care. The bill has been signed by the governor.

Medical Education

SF 266 contains funding for the statewide family practice residency program at a level of \$1,990,327 for the fiscal year beginning July 1, 1995. This compares to \$1,779,326 for the current fiscal year.

SF 266 also appropriates \$770,000 for the University of Iowa's primary care initiative with \$330,000 of that amount for the department of family practice.

The bill also contains continued funding for the forgivable loan program at the University of Osteopathic Medicine and Health Sciences. The bill establishes a new chiropractic graduate student forgivable loan program. Up to \$1,100 in loans will be forgiven per year for up to four years of practice in Iowa after completion of training at an Iowa chiropractic school and a residency.

Domestic Abuse

SF 367 relating to domestic abuse was

approved by both houses. The bill:

- requires the attorney general to develop written procedure and policies to be followed by prosecuting attorneys in domestic abuse cases;

- gives the juvenile court jurisdiction over juvenile batterers, requires juvenile batterers to attend a treatment program and allows a parent to file a domestic abuse complaint on behalf of a minor child;

- allows the court to order the defendant to pay plaintiff's attorneys fees and court costs in domestic abuse cases;

- provides for enforcement of protective orders issued in other states.

As of publication, this bill had not been signed by the governor. **IM**

Other bills

Passed:

- Child death review teams — SF 208
- Child support: state license revocation allowed for nonpayment — SF 149
- Commitment criteria — HF 337
- Drunk driving restrictions — SF 446
- Insurance - individual insurance reform and state tax deduction — SF 84
- Mental health coverage - study of cost and cost effectiveness — SF 347
- Podiatrists renamed "podiatric physicians" — SF 152
- Sex offender registry — SF 93
- Sexually violent predators — SF 432

Not passed:

- Abortion: statistical reporting — HF 522
- Abortion: mandatory parental notification — SF 13
- Autopsy: religious exemption — SF 354
- Helmet laws for both bicycles and motorcycles
- Medical records: copying charge limits — SF 258
- Nurse practitioners: mandatory direct reimbursement
- Physician assistants: change in licensure and supervision requirements, direct reimbursement
- Tobacco: improvements in clean indoor air act and restricting youth access to tobacco products

Medical Economics

AT A GLANCE

Eighty of America's 126 medical schools are addressing the issue of cost containment in a required course; 31 have an elective course. Just one year ago, one medical school had such a course. US Healthcare and Humana are establishing summer programs for medical students to gain first-hand experience with HMOs.

Federal researchers report nearly 14 million Americans — 7% — have a problem with alcohol. The problem is worse among men and more common among young people ages 18-29. Young non-black men were twice as likely to have a drinking problem as young black men.

The emergence of dental HMOs is rapidly changing the business of dentistry, Dow Jones News reported recently.

Important CLIA bill introduced

A bill which would exempt from the Clinical Laboratory Improvement Act (CLIA) all physician office testing except for Pap smears was introduced last month by Ways and Means Chairman Bill Arthur (R-Texas).

Rep. Thomas Bliley (R-VA) has promised the American College of Physicians he'll hold hearings on the legislation this summer. Rep. Bliley's Commerce Committee has jurisdiction over CLIA.

The bill represents mutual efforts on the part of the House, the Senate and the White House to ease regulatory burdens on physicians and laboratories. All three are working with HCFA regarding regulatory reforms.

A second major focus of attention is physician paperwork, including the Stark "attestation forms" which require physicians to tell HCFA what they own and where their "financial interests" are.

Watch the Medical Economics page in future issues for updates on regulatory relief.

Investors eye Medicare market

Despite differences in reimbursements, more HMOs are eyeing cash payouts in the Medicare marketplace and may enter the business in the next few years, *Investors Business Daily* reported recently.

Currently, 157 of America's approximately 560 HMOs offer a Medicare product. Currently, HMOs are flocking to the counties in Florida, New York and California where Medicare normally pays an HMO \$500 to \$700 per patient each month.

Great disparities in rates still make it financially unrealistic for some HMOs to serve elderly in many regions.

Medical futility guidelines needed

There may be occasional misunderstandings by some physicians on the concept and

application of medical futility rationale, according to a recent article in JAMA.

The article is based on a recent study to determine use of medical futility rationale in Do Not Attempt Resuscitation (DNR) orders for inpatients. The researchers found evidence of misunderstandings in the application of quantitative (low probability of successful cardiopulmonary resuscitation) and qualitative (poor quality of life if CPR were successful) futility.

The researchers believe intervention with less than a 5-10% chance of success is quantitatively futile therapy. A figure of less than 1% has been proposed.

The authors said application of qualitative futility to DNR orders must be preceded by a discussion of quality of life issues with the patient or surrogate and that education about medical futility must be incorporated into medical schools, residencies and continuing medical education programs.

In late April, the IMS House of Delegates approved a resolution to encourage the AMA Council on Ethical and Judicial Affairs to continue reviewing ethical issues related to appropriate care at the end of life.

Supreme Court ERISA ruling

A ruling by the US Supreme Court demonstrates there is a limit to ERISA's pre-emption power. The court voted unanimously to approve New York State's practice of adding surcharges onto hospital bills paid by commercial insurers, HMOs and employee benefit plans to raise revenue to offset the expense of indigent care and effectively subsidize Blue Cross Blue Shield.

While the case does not technically affect self-insured plans, it leads the way for lower courts to reach the conclusion that the surcharge imposed on self-insured payers would not be pre-empted under ERISA.

Opponents of the practice argued that ERISA prohibits states from passing laws that affect employee benefit plans. **IM**

Practice Management

DEA registration numbers

Physician Drug Enforcement Administration (DEA) numbers were the focus of two resolutions passed by the Iowa Medical Society House of Delegates at its 1995 House of Delegates meeting.

The House resolved that the IMS oppose the use of DEA registration numbers for any purpose other than verification to the dispenser that the prescriber is authorized by federal law to prescribe controlled substances.

The House also resolved that the IMS encourage physicians to report any inappropriate requests for DEA numbers to the Iowa Board of Pharmacy Examiners and educate physicians on the reporting process.

These actions were the result of various payers and care delivery systems seeking to use DEA numbers as physician ID numbers. IMS policy parallels AMA policy in the belief that there are other appropriate numbers to use to identify physicians and the DEA number should not be used for this purpose.

For more information, call Barb Heck at the IMS, 515/223-1401 or 800/747-3070.

Directory of Practice Parameters

The AMA has released its Directory of Practice Parameters, medicine's most comprehensive index of parameters, clinical guidelines and other patient management

strategies. The book includes a list of nearly 1800 practice parameters (including 400 new listings) developed by 75 physician organizations and other groups. For more information, call the AMA at 800/621-8335.

Part B newsletter available through IMS

The IMS has available *Part B News*, the nation's leading independent Medicare newsletter, at a special discount for IMS members. Through the IMS, you can save \$107 off the regular subscription price.

Part B News is packed with the latest Medicare payment policy changes and dozens of tested reimbursement tips and clean-claim strategies. When you subscribe, you'll also receive a complimentary "Plain English Guide to Medicare Part B Reimbursement".

For more information on *Part B News*, call Linda Tideback at the IMS, 515/223-1401 or 800/747-3070.

Phase-in for CPT E & M guidelines

Between May 1 and July 31, 1995, carriers will begin a phase-in process to review records documentation to support CPT E & M code billing using the HCFA E & M documentation guidelines. Beginning August 1, 1995, E/M codes will no longer be excluded from the Medicare medical review system. Carriers will vary in their timetables for utilizing the guidelines in reviewing E/M codes. **IM**

AT A GLANCE

As managed care moves into Iowa, physicians are being asked to sign contracts under which they will provide care. Many physicians have little experience with such contracts. The IMS advises physicians to consider this checklist of contract pitfalls:

- Does the contract contain a 'hold harmless' clause which shifts responsibility for liability from the managed care organization to the physician?

- Does the contract give you due process rights upon termination?

- Does the contract contain restrictions such as non-compete covenants?

- Does the contract contain an 'evergreen' clause which allows automatic renewal?

Finally, never sign a contract until you have read it thoroughly and understand it completely. You may wish to consult an attorney.

PRACTICE MANAGEMENT WORKSHOPS FOR YOU

QUALITY IN THE MEDICAL OFFICE

Wed., Sept. 6

Sioux City

Wed., Sept. 20

IMS headquarters

Wed., Sept. 27

Burlington Medical Center

This course examines trends in quality including outcome measures and practice parameters.

For more information or to register for any IMS practice management workshop, call Mary Reinsmoen or Sherry Johnson at IMS Services, 515/223-2816 or 800/728-5398.

CODING SEMINARS

JUNE 13 AND 14

(All sessions at Best Western, Des Moines International)

Pediatric, Primary Care Coding

June 13

Surgery Coding

June 14

Taught by Nancy Maguire, director of education and dean of the American Academy of Procedural Coders.

Practice Management

continued

MIDWEST MEDICAL INSURANCE COMPANY FOCUS ON RISK MANAGEMENT

Jousting comments

Physicians and other health care professionals can inadvertently prompt a patient to file a malpractice claim by making "jousting" comments.

"Jousting" is arguing, belittling, criticizing or complaining about another provider's care of the patient. Often, such comments are based on incomplete knowledge of the facts surrounding the initial care.

Plaintiff attorneys love to find evidence of conflict among a patient's health care professionals — it makes it easier to develop a case

against a physician.

Of course, inappropriate care should never be covered up, but peer review or quality assurance committees — not the medical record — are the appropriate places to address disagreements regarding judgement or treatment choices.

For further information, contact Lori Atkinson, MMIC risk management coordinator, MMIC West Des Moines office, PO Box 65790, West Des Moines, 50265, 800/798-9870 or 515/223-1482.

PHYSICIANS HELP CARING PROGRAM REACH UNINSURED CHILDREN

Janet is a smart and pretty 10-year-old who lives in a small town in Iowa. Like other kids her age, she likes to ride her bike, play sports and climb trees.

Her mom and dad are glad Janet is healthy and active, but at the same time, they cannot help wishing Janet would not play so hard. The company Janet's dad works for dropped health insurance coverage for employees and the family has not been able to find a policy to replace it—at least not one the family can afford.

If Janet were to break an ankle, the hospital bills could wipe out the family financially. Even a couple visits to the doctor for a simple sprain or ear infection can cost almost as much as a week's worth of food.

So whenever Janet has a fever, her parents try not to panic. They know they should take Janet to a pediatrician for a checkup—it's been a couple of years since she had one—but they have no idea when they will be able to afford it.

In Iowa, more than 25,000 children are growing up without health insurance coverage. Most are children of working parents whose income is too high for Medicaid, but too low to afford health insurance or routine medical care on their own. These are the children physicians can refer to the Caring Program for Children.

"These really are children at risk—at risk of getting sick and not having the medical care they need to get better and at risk of not getting the preventive care they

need to stay healthy in the first place," said Molly Kurtz, administrator of the program. Created and administered by the Caring Foundation, a non-profit affiliate of Blue Cross and Blue Shield of Iowa, the Caring Program currently provides health insurance benefits free of charge for more than 2200 youngsters statewide and has the ability to cover even more.

Children enrolled in the Caring Program receive basic health care benefits, checkups and immunizations. These services are provided by doctors who donate a portion of their normal fees back to the program, making it possible for the program to stretch private funding to reach many more children with the same dollars. Over 100 Iowa hospitals and 2000 physicians participate in the program.

Physicians and hospitals refer uninsured children to the program along with school nurses and county DHS offices. Enrollment kits can be made available in your office or clinic. Call 515/245-4693 for more information.

Major contributors to the program include the State of Iowa, Farm Bureau, Pioneer Hi-Bred International, Norwest Bank and Proctor and Gamble.



Newsmakers

Awards, appointments, etc.

Forty-three Iowa physicians were accorded Life Membership in the Iowa Medical Society at the opening session of the Society's House of Delegates meeting Saturday, April 29 at the Marriott Hotel. They are: **Robert Allen, MD**, Burlington; **William Baird, MD**, Ames; **Elmer Bean, MD**, Council Bluffs; **James Coffey, MD**, Emmetsburg; **Eugene Coffman, MD**, Bellevue; **Russell Conkling, MD**, Cedar Rapids; **Dcan Cooper, MD**, Fort Dodge; **Thomas Coriden, MD**, Sioux City; **Richard Corton, MD**, Waterloo; **Robert Donlin, MD**, Harlan; **Harley Feldiek, MD**, Iowa City; **Frederick Fuerste, MD**, Dubuque; **Louis Greco, MD**, Boone; **Charles Gutenkauf, MD**, Des Moines; **John Huey, MD**, Cedar Rapids; **Robert Jongewaard, MD**, Wesley; **James Kennedy, MD**, Coralville; **Walter Kopsa, MD**, Tipton; **Otto Kruse, MD**, Tipton; **Rufus Kruse, MD**, Marshalltown; **Jean Le Poidevin, MD**, Waterloo; **Edward Mason, MD**, Iowa City; **Emmett Mathiasen, MD**, Council Bluffs; **Roger Mattice, MD**, Emmetsburg; **Theodore Mazur, MD**, Burlington; **Richard Miller, MD**, Waterloo; **Robert Morrison, MD**, Waterloo; **Jack Moyers, MD**, Iowa City; **Gerald Nemmers, MD**, Washington; **Don Newland, MD**, Des Moines; **Loran Parker, MD**, Des Moines; **Gordon Rahn, MD**, Mt. Vernon; **John Singer, MD**, Iowa City; **Glenn Skallerup, MD**, Red Oak; **William Spence, MD**, Osage; **Warren Swayze, MD**, Muscatine; **Joel Teigland, MD**, Des Moines; **John Thomsen, MD**, Armstrong; **Russell Van Wetzling, MD**, Bettendorf; **Donald Wagner, MD**, Sioux City; **Janet Wilcox, MD**, Iowa City; and **Grey Woodman, MD**, Clinton. **Dr. Russell Gerard**, longtime Waterloo surgeon, has retired after 53 years of medical practice. Dr. Gerard now conducts Allen Memorial Hospital's largest fund-raising project—a complex named the Russell S. Gerard II, MD Hall—which will house Allen College, Allen Memorial Hospital School of Nursing and Radiologic Technology Education Program. **Dr. Ronald Lauer**, professor of pediatrics and preventive medicine, UI

College of Medicine, was the primary author of a May 10, 1995 article in *JAMA* entitled "Children benefit from moderately low-fat diets." **Dr. J. David Henderson** has begun practice at Ottumwa Family Practice. Dr. Henderson received his medical degree from Memorial University of Newfoundland, Canada. **Dr. Charles Wadle**, Des Moines, has been certified by the American Board of Psychiatry and Neurology in the Added Qualifications in Addiction Psychiatry. **Dr. Kendall Reed**, Des Moines, has been appointed by the American College of Surgeons for a three-year term as cancer liaison physician for the Mercy Cancer Center program. **Dr. Charles Clark**, professor of orthopaedic surgery, UI College of Medicine, has been elected to the board of directors of the American Academy of Orthopaedic Surgeons. **Dr. Otmar Albrand**, neurosurgeon, has begun practice at Grandview Medical Center in Dubuque. **Dr. John Strauss**, UI College of Medicine professor and head of dermatology, has been awarded the American Academy of Dermatology Gold Medal, its highest honor. The award recognizes Dr. Strauss' contributions as a clinician, educator and researcher in dermatology. **Dr. John Wollner**, Cedar Rapids dermatologist, has received the first Cancer Survivor Advocate of the Year Award, presented by the Linn County Unit of the American Cancer Society. The award recognizes an outstanding contribution of time and energy which improves the lives of cancer survivors or promotes cancer awareness, education, prevention or care. **Dr. Robert Wallace**, professor of preventive medicine and environmental health, UI College of Medicine, was selected as one of six new members of the National Institute on Aging's National Advisory Council on Aging.

Deceased members

Arthur Austin, MD, 73, radiology, Hiwasse, Arizona, died October 2

Michael Colln, MD, 43, nuclear medicine, Des Moines, died January 11 **IM**

AT A GLANCE

Allen Health Systems in Waterloo plans to merge with Iowa Health System in Des Moines. Allen Health Systems includes Allen Memorial Hospital, a 240-bed medical center serving an 11-county area of northeast Iowa. With the merger, Iowa Health System now has 1975 licensed beds.

Dr. David Coster, of Surgical Associates of Grinnell, has been selected as Iowa's top "Outstanding Young Iowan" by the state's Jaycees. Dr. Coster is director of trauma service at Grinnell Regional Medical Center and is credited with establishing a morbidity and mortality conference, expanding surgical services to include general thoracic and vascular surgery and expanding the functions of the hospital's radiology department. The Jaycees cited him for his role in making "major changes . . . in the pre-hospital care of patients, improving safety factors and response times."

IMS, IOWA PHYSICIANS *focus on* CHMIS

The 1994 Iowa Legislature passed a law establishing the Community Health Management Information System for Iowa. The CHMIS will affect the practice of every Iowa physician. As the details of Iowa's CHMIS are determined, it is imperative for physicians to stay involved in the process.

Editor's note: The following is a report given to the IMS House of Delegates April 29, 1995 by Sterling Laaveg, MD, a member of the Iowa Medical Society's Ad Hoc Committee on CHMIS.

CHMIS, the Community Health Management Information System, has become a key issue for Iowa physicians and will affect the practice of every physician in Iowa.

In the early 1990s, there was renewed interest in health data, much of this fueled by the proposed national health reform initiatives. Iowa took the lead and began to work for health reform at the state level, and the need for a valid and widely accepted health data base became obvious.

The Iowa Health Data Commission and other interested parties began to study what became known as CHMIS. At the direction of IMS leadership, the IMS participated in the planning and discussion process. Although the IMS did not initially favor development of a state health data base, it became clear that the Iowa Legislature favored and had enough support to pass the CHMIS bill. Therefore, IMS officers felt it was important for the IMS to

continue in the planning process to influence the development of the CHMIS. The IMS was successful in amending the original legislation to provide for implementation on a phased-in basis, with electronic claims transmission the focus of Phase I.

Governing Board oversees CHMIS

In 1994, the Governor signed CHMIS into law. The bill provides for establishment of an integrated electronic health management information system for transmitting information for health claim processing. The bill also provides for a data storage repository to give patients, physicians, hospitals and others information on which to base decisions on quality and effectiveness of care.

The law provides for a 12-person Governing Board consisting of two physicians, two hospital representatives, two payer representatives and six consumer representatives who have authority for implementing the CHMIS. The state insurance division will enforce the CHMIS law.

**It became clear
the Iowa
Legislature favored
and had
enough support to
pass the
CHMIS bill.**

STERLING LAAVEG, MD
Dr. Laaveg is a member of the Iowa Medical Society's Ad Hoc Committee on CHMIS and newly-elected IMS vice-president. He is an orthopedic surgeon in Mason City.

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Iowa Medical Society Statement of Policy on CHMIS (Community Health Management Information System)

Adopted April 30, 1995

The Iowa Medical Society (IMS), on behalf of physicians and patients, maintains an active interest and continuing involvement in the Iowa Community Health Management Information System (CHMIS) initiative and its implementation. IMS representatives meet regularly to follow developments and influence process, procedure and outcomes. The IMS CHMIS committee includes physician members of the CHMIS Governing Board, each of the five CHMIS advisory committees and other IMS member physicians.

This Statement of Policy has been formulated to reflect the IMS position on CHMIS and guide IMS member involvement in CHMIS development.

1. Development and implementation of the Iowa Community Health Management Information System (CHMIS) must continue to be under the overall direction of a broadly representative Governing Board which includes physician representatives.

It is of critical importance that the IMS CHMIS Committee and physician representatives on the Advisory Committees provide physician input and guidance in the decision-making process to achieve the mission of the Iowa CHMIS as listed below:

- Reducing the cost, improving the efficiency, and simplifying the processing of claims and payment transactions;
- Providing an efficient system to share information on appropriateness, efficiency, and effectiveness of health care services to assist in the improvement of the quality of the health care system for Iowans;
- Providing data for research; and
- Supplying information for educational purposes to enhance the health status of Iowans.

2. Priority attention must be given to assuring confidentiality of patient data, physician-patient information, physician-physician information and other sensitive information. In addition, a method must be developed to assure the maintenance of security in transmitting and accessing data in the CHMIS repository and handled through the CHMIS networks.

A mechanism must be developed to ensure that individuals and/or organizations do not breach confidentiality; penalties must be enforced.

There is a need for specific, carefully reviewed guidelines regarding which entities or individuals will have access to part or all of the database, with special attention to patient specific data and physician specific data.

3. All networks should be required to meet or exceed Iowa CHMIS Network Criteria set by the Governing Board.

Approval of criteria for certification of CHMIS networks shall be through a public process with opportunity for public comment.

Rules relating to certification of networks shall provide a mechanism for receiving complaints and for decertification of a network for failure to meet approved criteria including confidentiality.

Certification criteria shall be based on objective standards.

The IMS favors the certification of multiple networks which meet approved criteria.

4. Expense and revenue sources for the Iowa CHMIS must be clearly defined. Cost/revenue analysis should be conducted on each phase of

This IMS policy has been formulated to reflect the IMS position on CHMIS and guide IMS involvement in CHMIS development.

continued

The costs to implement, operate and maintain the Iowa CHMIS should not be paid solely by physicians and other providers.

CHMIS by the Governing Board.

The IMS should do an internal review of any cost/revenue analysis and if necessary build models which would demonstrate the cost variations which could be expected under CHMIS.

The Phase I analysis should be completed by October, 1995.

The costs to implement, operate and maintain the Iowa CHMIS should not be paid solely by physicians and other providers.

Office costs to implement, operate and maintain the Iowa CHMIS should remain the same or reduce the claim filing costs for physicians and other providers.

5. All data collection and analysis efforts in the state should be coordinated through CHMIS to minimize duplication and reduce costs. It is believed that all future data reporting requirements should come through CHMIS.

6. The IMS supports a phased-in approach to implementation of the Iowa CHMIS. The following policy should guide the IMS during each phase of implementation.

PHASE I

Collection and Submission of Data
(Legislative requirement that this phase be operational by July 1, 1996)

a. In order to gain efficiency in HCFA 1500 claims processing, a standard claim format (ANSI format), remittance format and patient eligibility format must be enforced for all payers. Strict limits must be placed on requirements for supplemental information.

b. All insurance claims data must be included in the database. Any necessary waivers or other

requirements to accomplish this must be pursued.

c. Payment deadlines must be established to assure prompt payment to physicians by payers.

d. Precertification and eligibility verification information must be accessible through the system at the time of service. If not available by July 1, 1996, Phase I should be delayed.

e. All providers, as defined in Iowa Code Chapter 144C (Senate File 2069), should implement Phase I simultaneously or if not possible, Phase I should be delayed.

PHASE II

Expanded Data Collection and Submission
(Legislation requires development of definitions to submit to Iowa General Assembly no later than January 1, 1999 for implementation by July 1, 1999)

a. Further definitions of the data included in Phase II is necessary. Phase II includes: clinical data sets, laboratory tests, x-ray results, and inpatient pharmacy codes; measures of functional outcomes; provider activity records for those in and not in organized delivery systems.

b. Submission of data should be in a standard format (ANSI or similar national format).

PHASE III

Totally Automated Status
(Only implemented after Phase I and Phase II upon approval of Iowa General Assembly)

a. The IMS opposes the creation of a central repository to collect, analyze and disseminate information from patients' medical records.

b. Further physician study of the proposed collection and transfer process is required before support can be given to Phase III.

continued from page 242

The CHMIS law speaks to the importance of confidential transmission and storage of data. The Governing Board is to establish operating policies; the Insurance Division is to adopt rules to ensure confidentiality of information and access only to authorized parties. The Governing Board has established five advisory committees. The IMS has two representatives on the Governing Board and 10 members or staff on the advisory committees.

What are physicians required to do?

Providers will be required to submit health claims via electronic transmission beginning July 1, 1996.

Payers will be required to accept a standard electronic transmission claim format for all claims activity. They will also be required to transmit eligibility verification and remittance advice electronically.

Certified transaction networks will be approved to operate in the electronic transmission environment.

CHMIS will be implemented in three phases. The focus now is on Phase I, which requires physicians to submit HCFA 1500 claim forms electronically starting July 1, 1996.

As the CHMIS design evolves, it is clear that there are two main issues of concern to physicians in Phase I: 1) protecting the confidentiality of patient-specific medical information transmitted and stored in the CHMIS environment; and 2) assuring that the cost to implement, maintain and operate the Iowa CHMIS does not increase the cost of claim filing for physicians.


It appears several aspects of the CHMIS

will be positive for physicians:

- Standardization of the claim filing form and acceptance by all payers.
- Strict limits on supplemental information required by payers to process claims.
- On-line electronic verification of patient insurance eligibility.
- Electronic payment remittance advice transmitted to physicians and the option of electronic funds transfer if desired.
- An all-payer, all-patient data base used for policy analysis and health research.

The IMS, through its committee and representatives on five advisory committees and the CHMIS Governing Board, has been heavily involved in influencing the interpretation and implementation of CHMIS. Our goal is to provide leadership that will assure the CHMIS is implemented in a manner that will benefit physicians and patients. In particular, our attention is focused on confidentiality of patient-specific medical information and upon who will bear the cost of implementing the system.

IMS policy guiding physician involvement

We have developed a statement of policy which we propose to guide IMS involvement in CHMIS. There are still many, many important issues to decide as CHMIS evolves and is implemented in Iowa. Physician members of the IMS will stay involved and active in the five advisory committees and at the Governing Board level. It is imperative for all Iowa physicians to stay informed and provide input to IMS leadership as we work to influence the details of CHMIS implementation in Iowa. 

Our goal is to provide leadership that will assure the CHMIS is implemented in a manner that will benefit physicians and patients.

Let Us Help You Help Others Today!

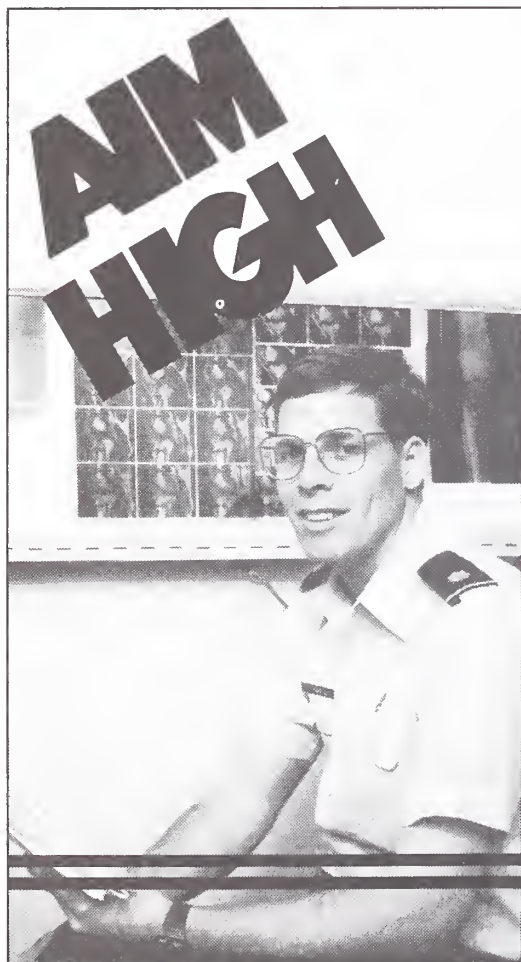
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The Journal

of the Iowa Medical Society

Duodenal web with preduodenal portal vein

● SERGIO GOLOMBEK, MD; JAGADISH BILGI, MD; ONEYBUCHI UKABIALA, MD

Congenital duodenal obstruction is an uncommon but serious condition. Despite recent improvements in surgical care of the neonate, duodenal atresia continues to be associated with a significant mortality rate. Prematurity, associated anomalies, nutrition and marginal pulmonary status present significant intraoperative and postoperative challenges.¹ The survival rate of 72% in 1973 has increased dramatically due to improvement in neonatal intensive care, rapid recognition and management of other anomalies, increased use of nutritional support and improved respiratory therapy.²

Case report

A two-week-old white male born of a normal pregnancy by spontaneous vaginal delivery, was admitted to Raymond Blank Memorial Hospital for Children with a history of projectile vomiting since birth, two or three times per day, either before or after feedings. The vomitus was digested formula, sometimes tinted with yellow. Fever and diarrhea were absent.

Physical examination revealed an alert, afebrile "hungry-looking" white male with vigorous cry, dry lips, "sticky" mouth and decreased skin turgor. Vital signs on admission were within normal limits. Body weight of 3.2 kg (25th percentile) was similar to the birth weight of 3.3 kg. The oral mucosa was moderately dry and the soft, non-tender abdomen had neither palpable masses nor visceromegalies. Although peristalsis was not visible, positive bowel sounds were present throughout.

With the assessment of vomiting and concomitant mild to moderate dehydration, the patient was admitted to the pediatric ward and started on intravenous fluids (maintenance plus 7%). A real-time ultrasound scan of the

abdomen revealed neither a dilated nor an elongated pylorus. Both stomach and duodenum were filled with gas.

Due to the persistence of the symptoms in the absence of positive findings, an upper gastrointestinal series was performed. Ten ml of barium were injected through the nasogastric tube followed by 40 ml of air. Barium flowed rapidly through a fairly normal and almost patulous pylorus and encountered a peculiar structure in the proximal C-loop with further distention of the proximal duodenum. An obstructing membrane within the proximal C-loop with a pin-hole opening distally was clearly apparent (Figure 1). At no time during the exam was gastroesophageal reflux observed. Although very small quantities of barium passed into the distal bowel, it was suspected that the ligament of Treitz was normal in position. In consultation with pediatric surgeons, an exploratory laparotomy was performed.

The patient was found to have a Type I duodenal atresia with a wind-sock duodenal



Figure 1. Obstructing membrane in the proximal C loop. The outflow of barium from the proximal duodenum is seen to occur through a very small opening in the obstructed segment. Moderate distention of the proximal duodenum is apparent.

The IMS Education Fund has designated this article as the Henry Albert Scientific Presentation Award for June 1995.

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Duodenal web with preduodenal portal vein

continued



Figure 2. Preduodenal portal vein (lifted by hemostat). This vessel was located above the proximal segment of the second part of the duodenum.

membrane containing at its summit a hole measuring about 0.5 cm in diameter. The distance from the membrane attachment on the inside of the duodenal wall to its summit measured about 2.5 cm. The common bile duct ran within the posteromedial aspect of the membrane to open on its inferior surface about 0.5 cm proximal to its summit. There also was a preduodenal portal vein overlying the proximal portion of the second part of the duodenum exactly over the operative field (Figure 2). The stomach and the first portion of the duodenum were hugely dilated and hypertrophic. The duodenal web was excised and a side-to-side duodenoduodenostomy and appendectomy performed.

An upper gastrointestinal series four days after surgery showed barium passing rapidly through into the distal duodenum. Swelling was seen along the lesser curvature or inferior aspect of the duodenal sweep, presumably post-surgical edema. The obstruction appeared resolved and remnants of the duodenal web were not apparent.

Recovery was excellent. He was treated with ampicillin and tobramycin for three days. After two days of total parenteral nutrition, enteral feedings were started on the third post-operative day. On the fourth day post-operatively the patient was discharged.

Discussion

Most of the 19 infants with intrinsic duodenal obstruction in the study of Mooney *et al* had Down's syndrome and a number of other associated anatomical anomalies including

ventricular septal defect, esophageal atresia and tracheoesophageal fistula, dextrocardia and other complex cardiac malformations.² Of the 49 patients with congenital duodenal obstruction in the study of Akhtar and Guiney, all but four had Down's syndrome; 78% had other associated congenital anomalies, and, at surgery, three were found to have the wind-sock anomaly, a variation of the intact membrane (Type I atresia).³ The membrane protrudes distally into the duodenum and, consequently, the actual level of obstruction may be several cm distal to the point of the membrane origin.

Various operative techniques have been used in the past for the treatment of congenital duodenal obstruction including duodenoduodenostomy and duodenojejunostomy and excision or incision of the web.⁴

Spigland *et al* reviewed 33 neonates who underwent surgery for congenital intrinsic duodenal obstruction.⁵ Bilious vomiting and intestinal obstruction were the most frequent symptoms. Hydramnios and Down's syndrome were present in 75% and 21% of the cases, respectively. Findings at laparotomy included duodenal atresia ($n = 14$), annular pancreas ($n = 11$) and duodenal diaphragm ($n = 8$).

The most frequent surgical procedure was side-to-side duodenoduodenostomy followed by duodenojejunostomy and resection of web with duodenoplasty. Bowel transit was reestablished at a mean of 13.1 days (range 6 to 45 days). These investigators favored the partial web excision with Heineke-Mickulicz type duodenoplasty for the treatment of intrinsic duodenal webs when the proximal duodenal pouch was not excessively dilated, because bowel transit time was most rapidly restored to normal when compared with other bypass procedures.

In an attempt to reduce the risk of unexpected injury to the biliary tract during surgery, preoperative endoscopy has been routinely used since 1980 by Okamatsu *et al*, who reported the first successful treatment of congenital duodenal stenosis with endoscopic membranectomy.⁶ Endoscopic membranectomy can be performed with minimal surgical complications. Bile flow for the papilla of Vater should be confirmed prior to endoscopic dissection of the diaphragm. Preoperative evaluation for passage of the distal duodenum using fluoroscopy, and the possibility of bal-

loon catheter insertion through the opening before dissection is also important for successful endoscopic membranectomy.

According to Fernandes *et al*, only 63 cases of preduodenal portal vein have been reported in the literature.⁴ In general, this rare anomaly occurs in children in association with small bowel obstruction. Fernandes *et al* described a newborn infant who, after presenting with duodenal stenosis, monogolism and preduodenal portal vein, underwent duodenoduodenal anastomosis without mobilization of the portal vein.⁴

The embryogenesis of preduodenal portal vein could be explained by the persistence of a preduodenal vitelline communicating vein. Sixty-four percent of patients with preduodenal portal vein are children. Two-thirds of these cases are detected in the first week of life due to associated intrinsic duodenal anomaly, malrotation or Ladd's bands. Anomalies associated with preduodenal portal vein include annular pancreas, biliary atresia, preduodenal common bile duct and cardiovascular malformations. The role of preduodenal portal vein in the etiology of intestinal obstruction is controversial. In 80% of patients with preduodenal portal vein, an intrinsic lesion of the duodenum or malrotation is responsible for obstruction.⁷


The presence of preduodenal portal vein complicates surgery for duodenal obstruction. While integrity of the vessel must be preserved to avoid portal vein thrombosis, the duodenum cannot be completely divided and anastomosed anterior to the vein due to the proximity of the pancreas and common bile duct. Duodenoduodenal anastomosis is currently the procedure of choice to treat this anomaly. The anastomosis is created anterior to the portal vein between the segments of the duodenum immediately proximal and distal to the obstruction. The portal vein will then lie between the second portion of the duodenum and the newly created anastomosis.

Summary

This article described an unusual case of an infant with duodenal atresia and preduodenal portal vein without Down's syndrome or other anatomical anomalies associated with this condition. Duodenoduodenostomy was

effective. Enteral feeding was re-established 72 hours post-operatively and the patient was discharged home one day later.

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Service delivery to persons with HIV and AIDS

● EDWARD SAUNDERS, PhD, SUSAN DOLPHIN, MSW; BERY ENGBRETSSEN, MD

Given the magnitude of the AIDS epidemic, an objective of *Healthy People 2000* is to increase by at least 80% the proportion of HIV-infected people who have been tested for HIV infection.¹ In 1989, an estimated 15% of approximately one million HIV-infected people had been tested at publicly funded clinics; in 1991, nearly 2.1 million HIV-antibody tests were performed, compared with approximately 79,000 tests in 1985.² Of those tested in 1991, 57,879, or 2.8%, were HIV-positive.³

To promote expanded counseling and testing of persons at risk, the U.S. Public Health Service distributes funds authorized by the Ryan White Comprehensive AIDS Resources Act. Broadlawns Medical Center, Peoples Community Health Clinic in Waterloo, Community Health Care, Inc. in Davenport, Polk County Health Department, Black Hawk County Health Department, Central Iowa Chapter of the American Red Cross and Cedar AIDS Support System were active collaborators in this project.

Service model

The program provided a total spectrum of HIV-related services for the uninsured in each of three major population areas of Iowa: Des Moines, Waterloo and Davenport. Through the Community Health Centers (CHC) and affiliated agencies in each of these areas, testing and counseling are available for all persons at risk of HIV. In addition to anonymous testing, each CHC assures the provision of basic primary medical care for HIV/AIDS patients. Each community has active outreach and education programs targeted at minorities, substance abuse, STD and prison populations. By providing a coordinated program, administrative costs have

been kept to a minimum and persons with HIV and AIDS are provided the most humane and cost-effective care.

Other services provided by the program included immune status monitoring, the provision of AZT, Pneumocystis prophylaxis, cell counts, chest x-rays, and certain TB tests; plus coordination of speciality, mental health and inpatient services. Costly duplication of services is avoided and clients find an emotionally-supportive resource. In addition to health care, these needs may include: individual, group or family counseling; legal aid; housing assistance; financial assistance and transportation. Case managers do office visits, telephone contacts and home visits.

Findings from testing

In 1992, a total of 28,500 tests for HIV (including 4,500 for the prison system) were recorded by the University of Iowa Hygienic Laboratory. Of these tests, 6,509 (23%) were administered by sites in this program. Although 7,535 persons sought testing at program sites, only 6,509 tests were actually administered. The remaining 1,026 persons were counseled but not tested.

The four testing sites in this program were: Broadlawns Medical Center, Polk County Health Department, Black Hawk County Health Department and Community Health Care, Inc., Davenport. This is the first calendar year for which data is available from these testing sites. The Polk County Health Department attracted the largest number of persons seeking a test (4,937), followed by the Black Hawk County Health Department in Waterloo (1,241), Broadlawns Medical Center (899), and Community Health Care Inc., Davenport (457).

The average age of those who sought test-

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ing was 28.4 years. They were primarily low-income, although 41% had private insurance. The largest percentage of those seeking a test (77%) identified heterosexual contact as the probable route of exposure, followed by homosexual-bisexual exposure (7%), and I.V. drug use (3.5%).

Among the 6,509 tests administered, 37 persons were found to be positive for the HIV virus. When the Enzyme-Linked Immunosorbent Assay (ELISA) test, which detects antibody to HTLV-III, was positive, the Western Blot test was used to confirm the positive findings. Fifty-six percent identified homosexual contact as the source of the infection; 36.1% identified heterosexual contact; one person was homosexual with I.V. drug use; and two had undetermined exposure.

In 1992, 175 persons who were HIV positive or who had a diagnosis of AIDS were served by the program.

The average age of program participants is 34 years; the majority are Caucasian (75.5%), males (85.8%), whose primary route of infection is homosexual behavior (63.2%). Fifty-five (31%) of the program participants have a diagnosis of AIDS. (They are among the 108 new cases of AIDS reported in Iowa in 1992 and among the 425 cases reported since February 3, 1983 when the first case of AIDS was reported in Iowa.⁴)

Two women participants were pregnant in 1992. Sixteen program participants died in 1992 from diseases associated with AIDS.

Cost-effective care

A goal of the program was to provide humane and cost-effective care. Nationwide, it is forecast that the cost of treating all people with HIV will increase 21% per year between 1991 and 1994, and that \$10.4 billion will be spent on treating all people with HIV in 1994. The yearly cost of treating a person with AIDS is estimated at \$32,000; and the yearly cost of treating an HIV-infected person without AIDS is \$5,150.⁵ Based on cost data for 151 program participants in Iowa, outpatient (publicly-financed) costs in 1992 for HIV+ and AIDS clients totalled \$247,538; an average of \$1639 each. Inpatient costs for 17 program participants in 1992 totalled \$250,955; an average of

\$14,762 each.

Combined costs for inpatient and outpatient health care reached almost one-half million dollars for approximately 150 persons. This represents only a fraction of the total expenditures for clients, since the cost data is based on publicly-financed expenditures and does not include mental health and social support expenses. However, without the management of these cases by professional social workers and nurses, the costs of care might be expected to have been significantly greater.

Conclusion

If the experiences of Iowa mirror those of other sites nationwide, we can expect that HIV-positive persons identified early through testing will be better served and that individuals who test negative will modify their risky behavior as a result of the pretest and posttest counseling. It is projected that high risk populations—notably IV drug users, minorities and the prison population—will be better served in future years. Iowa has accepted the challenge of the National Commission on AIDS to “transform indifference into action.”⁶

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Note

This article was accepted for publication in 1993 when this project was fully operational; it has since been modified. ■

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Oath of Hippocrates still valid

The Oath of Hippocrates has been considered the earliest and most impressive document in medical ethics. Garrison in his monumental *History of Medicine* declares that Hippocrates was a product of the "classics period" (460-136 BC), a time never before or since that "so many men of genius appeared within the narrow limits of space and time." Contemporaries of Hippocrates included Sophocles, Euripides, Aristophanes, Socrates and Plato. Now this Oath after over 2300 years increasingly is being challenged; yes, even violated.

Perhaps there are medical graduates of recent years who were not required to adhere to the Oath or elected to reject it. For centuries here and abroad, the recitation of the Oath of Hippocrates was included when the medical student attained the title "physician".

What has prompted a degree of disclaim toward this time-honored Oath? Is it disrespect for its precepts? Is it due to an emerging social concept that freedoms of action need not be tempered with responsibility? It is a matter of greed for compensation for what in the terms of the Oath were considered a responsibility of one physician to all others? Or is this another inroad by the legal profession?

The latest thrust at demeaning the concepts of the Oath is seeking to hold patent rights on procedures and techniques, e.g., a particular method or operative incision, as was granted to

an Arizona surgeon who now seeks royalties to be paid by any other surgeon who uses the technique. Another patent has been issued for a method of detecting certain kinds of tumors. It has been time-honored that physicians shared their skills and discoveries of procedure.

Our Iowa Congressman, surgeon Greg Ganske, has introduced a bill (HR 1127) into Congress to limit the issuance of patents on medical procedures. More precisely the bill prohibits the issuance of a patent of "any invention or discovery of a technique, method or process for performing a surgical or medical procedure; administering a surgical or medical therapy; or making a medical diagnosis, except if the technique, method or process is performed by or is a necessary component of a

machine . . . which is itself patentable subject matter." Last year the AMA House of Delegates took a stand against medical and surgical procedures patents, declaring them unethical.

It is hoped Congress can understand the Hippocratic Oath. Does any other profession swear to an

Now this Oath after over 2300 years increasingly is being challenged; yes, even violated.

oath that has withstood over 2300 years of trial and testing? When I received my medical degree, the recitation of the Oath was a serious part of our graduation. How many of my colleagues can say the same? How many believe the entire Oath to be antiquated and no longer appropriate? **M**



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The advancement of practice

The advancement of medical care is a describable phenomenon in which the practicing physician has an essential role. That role, however, is not necessarily predictable.

Something happens on the way to the production of a medical textbook. Deliberative studies in the laboratory may result in recommendations for the use of a drug or procedure. If the recommendations are validated in controlled clinical trials, a paper may be prepared for the peer-reviewed literature. Other investigations may duplicate the published findings and subsequently the therapeutic innovation is triumphed at professional meetings and in clinical journals. Eventually, the widely accepted treatment is incorporated into standard medical texts.

This progress of events is of course only representative of the many scenarios that translate new knowledge into practice. The most ignored pathway of change begins with the inquisitive practitioner.

While elements of medical care become routine in the practice of the physician, the unexpected finding provides a challenge. The unusual symptom, the difficult-to-describe rash, the unanticipated improvement, the sudden deterioration—each of these patient developments should provoke the practitioner to ask why has this event happened. The medical texts, printed or on-line, may not offer an answer.

What is the practitioner to do in this situa-

tion? Generally the consultation or advice of a colleague is sought, to either confirm the observation or seek a plausible reason. We can read about many examples of how this process has been employed in the history of practice. There are images of studious physicians making detailed observations in bound notebooks. The observations may then lead to a letter or case study in a publication, a presentation to colleagues at a meeting or a telephone conversation with a medical school faculty member.

Each of these avenues can precipitate a change in medical practice. Consider our therapeutic friend, aspirin. Clinical observations have accounted for these dramatic understandings in the use of this ubiquitous drug within a generation: aspirin as a cause of chronic gastritis; aspirin as an etiologic factor in Reye's syn-

Something happens on the way to the production of a medical textbook.

text was necessary. **IM**

drome (a post-infectious encephalopathy of children); and aspirin as a preventive agent in coronary thrombosis.

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BC/BE family practitioner needed immediately for full practice in this friendly community. Practice includes:

- Competitive salary and benefit package
- Call schedule of 1:4
- 35,688 person draw area
- Affiliation with 98-bed, JCAHO accredited Perry Memorial Hospital.

Princeton, Illinois offers high quality schools and a safe environment in which to live and work, as well as various cultural and recreational activities. Contact:

**Marie Noeth at 800/438-3745
or fax your CV to 309/685-2574.**

Madison, Wisconsin, Urgent Care—Dean Medical Center a 300+ physician multispecialty group is seeking full time physician to assist in staffing our two urgent care centers. Qualified applicants should be BE/BC in family practice, emergency medicine or internal medicine with experience in pediatrics. Dean Medical Center operates two Urgent Care Centers 365 days per year, from 7:00 a.m.–10:00 p.m. All physicians employed at the urgent care centers are paid on an hourly basis and full time physicians are eligible to go on a shareholder track and buy into the corporation after two years of employment. Excellent compensation and benefits with shareholder eligibility after two years of employment. For more information contact Scott M. Lindblom, Dean Medical Center, 1808 W. Beltline Highway, PO Box 9328, Madison, Wisconsin 53715-0328, at work 1/800-279-9966 or 608/259-5151 or home 608/833-7985.

Advertising Rates and Data

Regular classified advertising sells for \$2.00 per line with a \$30 minimum per insertion. For members of the Iowa Medical Society the rate is \$20 per insertion. Display classified advertising sells for \$25 per column inch, per month. Sizes range from 1 column by 2 inches to 1 column by 6 inches. A variety of type sizes, borders, reverses or screens can be included in the ad. Blind box numbers are available upon request at no additional charge. Copy deadline is the 1st of the month preceding publication. Send or fax copy to Iowa Medicine, 1001 Grand Avenue, West Des Moines, Iowa 50265-3599, fax 515/223-8420.

Orange City, Iowa

Exceptional opportunity for full-time family practice physician to join an 8-provider family practice clinic. Fully integrated with hospital via employment contract with excellent benefit package. Hospital, clinic and long-term care facility remodeled in 1993. Family oriented Dutch community of 5,000 located 90 miles from Iowa Great Lakes. Excellent public and parochial school systems and liberal arts college.

Orange City Hospital and Clinic
400 Central Avenue NW
Orange City, Iowa 51041
712/737-5270

Ramsey Clinic—A 250-physician multi-specialty group based in downtown St. Paul operates a small network of clinics in Maplewood and western Wisconsin. We currently have 2 openings for board certified/board eligible family physicians at Ramsey Clinic-Maplewood and the Family Medical Clinic in Amery, Wisconsin. Both clinics boast personable physician colleagues and support staff, thriving practices, private-like practice settings and access to specialty consultations and administrative support. Excellent call schedule, a first year salary guarantee and comprehensive benefits package. Send CV to Aynsley Smith, Ramsey Clinic, 640 Jackson Street, St. Paul, Minnesota 55101 or call 612/221-4230.

Janesville, Wisconsin—Dean Medical Center, a 300-physician multispecialty group, is actively recruiting additional BE/BC internal medicine physicians to practice at the Riverview Clinic locations in Janesville, Milton and Delavan, Wisconsin. Traditional internal medicine and urgent care practice opportunities are available. Janesville, population 55,000, is a beautiful, family-oriented community with excellent schools and abundant recreational activities. Excellent compensation and benefits are provided with employment leading to shareholder status. Send CV to Stan Gruhn, MD, Riverview Clinic, PO Box 551, Janesville, Wisconsin 53547 or call 608/755-3500. An Equal Opportunity Employer.

Stoughton, Wisconsin—Dean Medical Center, a 350-physician multispecialty group is actively recruiting a BE/BC family physician for our Stoughton Clinic, which is located approximately 20 miles south of Madison (population 190,000). Currently there are 3 internists, 4 family practice physicians, one pediatrician and one general surgeon at this clinic. Call would be shared equally among the family physicians. The Stoughton Hospital is a 50-bed facility adjoining the new medical office building. Stoughton has a population of approximately 9,000 and growing with excellent schools and neighborhoods. This is an excellent position which enables you to live in a safe community with the cultural and professional resources of a larger city just minutes away. A two-year guaranteed salary plus incentive and benefits is being offered for this position. Contact Scott Lindblom, Dean Medical Center, 1808 West Beltline Highway, Madison, Wisconsin; 1-800/279-9966; 608/250-1550 (work); 608/833-7985 (home); or fax 608/250-1441.

Springfield, Missouri—Bass Pro Shop and 40 miles to Branson. BE/BC FPs. OB optional, salaried position and production bonus, call 1:7, teaching hospital, university community. Contact Vivian M. Luce, Cejka & Co., 1/800-765-3055 or fax CV for immediate attention to 314/726-3009 (IMs welcome).

Emergency Medicine Administrative Opportunity Ottumwa, Iowa

Exceptional opportunity for primary care trained or experienced emergency physician.

- 19,000 Annual Volume
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Send CV or call Sheila Jorgensen
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PO Box 1260, Waterloo, Iowa 50704
800/458-5003 or fax 319/236-3644

Boone, Iowa

Seeking a quality emergency physician interested in a stellar emergency medicine practice. Full and regular part-time position available. Democratic group, paid St. Paul malpractice with unlimited tail. Excellent benefit package/bonuses to full-time physicians. Average volume with above-average compensation. **ACUTE CARE, INC.**, P.O. Box 515, Ankeny, Iowa 50021; phone 800/729-7813.

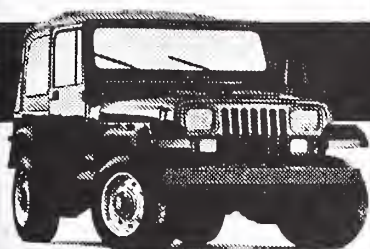
Janesville, Wisconsin—Dean Medical Center, a 300-physician multispecialty group, is actively recruiting additional BE/BC family physicians to practice at the Riverview Clinic locations in Janesville, Milton and Delavan, Wisconsin. Traditional family practice and urgent care opportunities are available. Janesville, population 55,000, is a beautiful, family-oriented community with excellent schools and abundant recreational activities. Excellent compensation and benefits are provided with employment leading to shareholder status. Send CV to Stan Gruhn, MD, Riverview Clinic, PO Box 551, Janesville, Wisconsin 53547 or call 608/755-3500. An Equal Opportunity Employer.

Emergency Medicine—Outstanding opportunities in emergency medicine available in a variety of Iowa and Minnesota locations for primary care trained or experienced emergency physician. Quality lifestyles in family oriented communities. Guaranteed compensation, paid malpractice, health/dental, life, disability. Send CV or call Sheila Jorgensen. Emergency Practice Associates, P.O. Box 1260, Waterloo, Iowa 50704; 800/458-5003, fax 319/236-3644.

115-Physician, Midwest Multispecialty—Seeking BC/BE candidates: dermatology, family medicine, pulmonology. Comprehensive health care center for 14 counties, population over 320,000. Two-year guaranteed salary, relocation and CME funds part of the many benefits. Safe, thriving family community with stable economy offers a rewarding quality of life. Purdue University offers academics, cultural events and Big 10 sports. Physician Recruitment, Arnett Clinic, PO Box 5545, Lafayette, Indiana 47904; 800/899-8448.

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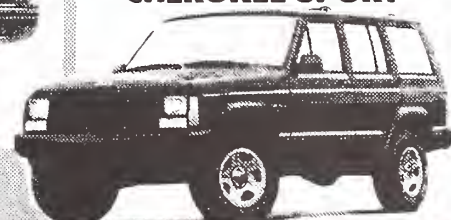
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Des Moines 50309
515/243-0590
Allergy & Immunology

Allergy Institute, PC
A.Y. Al-Shash, MD
R.K. Agarwal, MD
1701 22nd Street, Suite 201
West Des Moines 50266
515/223-8622

Pediatric and Adult Allergy, PC
Veljko K. Zivkovich, MD
Robert A. Colman, MD
1212 Pleasant, Suite 110
Des Moines 50309
515/244-7229
Asthma, Allergy & Immunology

Dermatology

Robert J. Barry, MD
1030 Fifth Avenue, SE
Cedar Rapids 52403
319/366-7541
*Practice Limited to Disease,
Cancer and Surgery of Skin*

Fort Dodge Medical Center, PC
Carey A. Bligard, MD, FAAD
James D. Bunker, MD, FAAD
800 Kenyon Road
Fort Dodge 50501
515/574-6850

Electrodiagnosis

John Milner-Brage, MD
208 St. Francis Professional Building
Waterloo 50702
319/234-6446
*Electromyography & Nerve
Conduction Studies
Certified by American Board of
Electrodiagnostic Medicine*

Emergency Medicine

Aeute Care, Inc.
P.O. Box 515
Ankeny 50021
515/964-2772 or 1-800/729-7813
*Comprehensive Emergency Medicine
Practice, Locum Tenens,
Doctor on Call*

Emergency Practice Associates
P.O. Box 1260
Waterloo 50704
1-800/458-5003
*Specialists in Emergency
Staffing & Emergency Department Services*

Family Practice

Aeute Care, Inc.
P.O. Box 515
Ankeny 50021
515/964-2772 or 1-800/729-7813
*Locum Tenens
Doctor on Call*

Infectious Diseases

**Chest, Infectious Diseases & Critical Care
Associates, PC**
Daniel H. Gervich, MD
Daniel J. Schroeder, MD
Ravi K. Vemuri, MD
Infectious Diseases
1601 NW 114th, Suite 347
Des Moines 50325-7072
24 Hours 515/224-1777

Infertility

Mid-Iowa Fertility, PC
Donald C. Young, DO
3408 Woodland Avenue, Suite 302
West Des Moines 50266
515/222-3060
*Reproductive Endocrinology/Infertility
IVF and GIFT Procedures
Donor Oocyte Program
Artificial Inseminations
Reproductive Surgery
Menopause Management*

Internal Medicine

Fort Dodge Medical Center, PC
Cardiology
Samir G. Artoul, MD, FICC
515/574-6840
Gastroenterology
Kenneth W. Adams, DO, AOBIM
General Internal Medicine
William C. Robb, MD
Richard H. Brandt, MD, ABIM
Grace Z. Ang, MD
800 Kenyon Road
Fort Dodge 50501
515/574-6820

Neurology

Iowa Medical Clinic Neurology
Andrew C. Peterson, MD
Laurence S. Krain, MD
600 7th Street SE
Cedar Rapids 52401
319/398-1721
*Neurology, EEG, EMG, Evoked Potentials
and Sleep Studies*

Fort Dodge Medical Center, PC
Jugal T. Raval, MD, MBBS
800 Kenyon Road
Fort Dodge 50501
515/574-6845

Neurosurgery

Iowa Medical Clinic
Neurosurgery
James R. Lamorgese, MD
Loren J. Mouw, MD
600 7th Street, SE
Cedar Rapids 52401
319/366-0481
Practice limited to Neurosurgery

Hosung Chung, MD
2710 St. Francis Drive, Suite 401
Waterloo 50702
319/232-8756; fax 319/232-5703
Practice limited to Neurosurgery

Neurosurgical Services LLP

Robert Hayne, MD
Thomas A. Carlstrom, MD
David J. Boarini, MD
 1215 Pleasant, Suite 608
 Des Moines 50309
 515/241-5760

Robert C. Jones, MD
S. Randy Winston, MD
Douglas R. Koontz, MD
 2600 Grand Avenue, Suite 210
 Des Moines 50312
 515/283-2217
Neurological Surgery

Chad D. Abernathy, MD
 1953 1st Avenue SE
 Cedar Rapids 52402
 319/363-4622
Neurological Surgery

Obstetrics/Gynecology

Fort Dodge Medical Center, PC
Brian L. Welch, MD
 800 Kenyon Road
 Fort Dodge 50501
 515/574-6870

Ophthalmology

Wolfe Clinic, PC
Russell H. Watt, MD
John M. Graether, MD
Gilbert W. Harris, MD
James A. Davison, MD
Norman F. Woodlief, MD
Eric W. Bligard, MD
David D. Saggau, MD
Steven C. Johnson, MD
Todd W. Gothard, MD
 309 East Church
 Marshalltown 50158
 515/754-6200

Satellite Offices
 Lakeview Medical Park
 6000 University Avenue, Suite 300
 West Des Moines 50266
 515/223-8685

804 South Kenyon Road, Suite 100
 Fort Dodge 50501
 515/576-7777

Sartori Professional Building
 516 South Division Street
 Cedar Falls 50613
 319/277-0103

214 - 13th Street Southeast
 Cedar Rapids 52403
 319/362-8032

Ophthalmic Associates, PC
Robert D. Whinery, MD
Stephen H. Wolken, MD
Robert B. Goffstein, MD
Lyse S. Strnad, MD
 540 E. Jefferson, Suite 201
 Iowa City 52245
 319/338-3623

North Iowa Eye Clinic, PC
Addison W. Brown, Jr., MD
Michael L. Long, MD
Bradley L. Isaak, MD
Randall S. Brenton, MD
James L. Dummert, MD
Mick E. Vanden Bosch, MD
 3121 4th Street, S.W.
 P.O. Box 1877
 Mason City 50401
 515/423-8861

Timothy F. Moran, Jr., MD
 United Federal Building
 700 4th Street, Suite 305
 Sioux City 51101
 712/252-4333

Satellite Clinics
 Horn Memorial Hospital
 700 E. 2nd Street
 Ida Grove 51445
 712/364-3311

Orange City Hospital
 400 Central Avenue NW
 Orange City 51041
 712/737-2426

General Ophthalmology

Orthopaedics

Iowa Orthopaedic Center, PC
Marvin H. Dubansky, MD
Marshall Flapan, MD
Sinesio Misol, MD
Joshua D. Kimelman, DO
Timothy G. Kenney, MD
Lynn M. Lindaman, MD
Jeffrey M. Farber, MD
Kyle S. Galles, MD
Scott A. Meyer, MD
Cassim M. Igram, MD
Donna J. Bahls, MD
Jill R. Meilahn, DO
Jacqueline M. Stoken, DO
 411 Laurel, Suite 3300
 Des Moines 50314
 515/247-8400

Orthopaedic Surgery

Fort Dodge Medical Center, PC
C. Mark Race, MD
 800 Kenyon Road
 Fort Dodge 50501
 515/574-6880

Otolaryngology

Iowa ENT, PC
Thomas A. Ericson, MD
Marshall C. Greiman, MD
Steven R. Herwig, DO
Thomas O. Paulson, MD
Mark K. Zlab, MD
 1-800/248-4443
 1215 Pleasant, Suite 408
 Des Moines 50309
 515/241-5780

1200 35th Street, Suite 200
 West Des Moines 50266
 515/225-7761
Satellite Clinics:

*Pella, Perry, Newton, Indianola,
 Oskaloosa, Guthrie Center, Knoxville*

Wolfe Clinic, PC
Michael W. Hill, MD
Daniel J. Blum, MD
 309 East Church
 Marshalltown 50158
 515/752-1566

Lakeview Medical Park
 6000 University Avenue, Suite 310
 West Des Moines 50266
 515/224-9533

Sartori Professional Building
 516 South Division Street
 Cedar Falls 50613
 319/277-3105
*Otolaryngology-Head and Neck Surgery,
 Facial Plastic Surgery, Allergy*

Phillip A. Linquist, DO, PC
 1000 Illinois
 Des Moines 50314
 515/244-5225
*Ear, Nose and Throat Surgery,
 Facial Plastic Surgery, Head
 and Neck Surgery*

(Continued next page)

Professional Listing Rates

Physician members of the Iowa Medical Society may advertise in this directory. Monthly rates are as follows: \$10.00 first 3 lines; \$2.00 each additional line. Billed yearly. May be prorated. Send or fax copy to Iowa Medical Society, 1001 Grand Avenue, West Des Moines, Iowa 50265-3599, fax 515/223-8420.

Iowa Head and Neck Associates, PC

Robert T. Brown, MD
Eugene Peterson, MD
Richard B. Merrick, MD
Peter V. Boesen, MD
Robert R. Updegraff, MD
 3901 Ingersoll
 Des Moines 50312
 515/274-9135

Dubuque Otolaryngology-Head & Neck Surgery, PC

Thomas J. Benda, Sr., MD
James W. White, MD
Craig C. Herther, MD
Thomas J. Benda, Jr., MD
 310 North Grandview Avenue
 Dubuque 52001
 319/588-0506

Otologic Medical Services, PC

Roger A. Simpson, MD
Guy E. McFarland, MD
Thomas F. Viner, MD
Douglas E. Dawson, MD
 540 E. Jefferson, Suite 401
 Iowa City 52245
 319/351-5680
 1-800/642-6217

*Maxillofacial, Plastic, Head & Neck
 Surgery*

Robert G. Smits, MD, PC

1040 5th Avenue
 Des Moines 50314
 515/244-8152
 1-800/622-0002

*Ear, Nose and Throat Surgery,
 Facial Plastic Surgery and Head and
 Neck Surgery*

Pain Management**Iowa Medical Clinic Outpatient Pain Treatment Center**

James R. LaMorgese, MD, FACS,
Neurosurgeon, Medical Director
Sandra Gannon, LSW, ACSW, Program Director
 600 7th Street SE
 Cedar Rapids 52401
 319/399-2013
*Neurology, Psychiatry, Anesthesiology,
 Rheumatology*

Physical Medicine & Rehabilitation**Genesis Regional Rehabilitation Center
 Genesis Medical Center**

1227 East Rusholme Street
 Davenport 52803
 319/383-1466

Maurice D. Schnell, MD
Farceduddin Ahmed, MD
Arthur B. Scarle, MD
Bogdan E. Krysztofiak, MD

Rehabilitation Medicine Associates

William D. deGravelles, Jr., MD
Charles F. Denhart, MD
Marvin M. Hurd, MD
William C. Koenig, Jr., MD
Karen Kienker, MD
Todd C. Troll, MD
Lori A. Sapp, MD
Younker Rehabilitation Center
Iowa Methodist Medical Center
 1200 Pleasant
 Des Moines 50308
 515/241-6434

2600 Grand Avenue, Suite 102
 Des Moines 50312
 515/283-1570

Pulmonary Medicine**Fort Dodge Medical Center, PC**

Robert C. Ang, MD, FCCP
 800 Kenyon Road
 Fort Dodge 50501
 515/574-6820

Chest, Infectious Diseases & Critical Care Associates, PC

Roger T. Liu, MD
Steven G. Berry, MD
Donald L. Burrows, MD
Michael Witte, DO
Gerard A. Matysik, DO
 1601 NW 114th, Suite 347
 Des Moines 50325-7072
 24 Hour 515/224-1777
Pulmonary Diseases

Surgery**Wendell Downing, MD**

1212 Pleasant Street, Suite 410
 Des Moines 50309
 515/241-5767
*Diseases and Surgery of the Colon and
 Rectum*

Fort Dodge Medical Center, PC

Ralph E. Woodard, MD, FACS
Dan P. Warlick, MD, FACS
 800 Kenyon Road
 Fort Dodge 50501
 515/574-6865

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Three important issues

This month's *Iowa Medicine* contains a guest editorial by Dr. Paul Seeböhm regarding the IMS Education Fund. The fund supports very worthwhile projects, including student loans. These loans are relatively low interest (7% this year) and play an important part in financing of many junior and senior medical student's education.

Current proposed federal legislation would require that interest on federal student loans be paid annually from the inception of the loan. Should this pass Congress, loans from the IMS Education Fund will be even more desirable.

The average formal loan debt load of currently graduating University of Iowa medical students is approximately \$50,000. That seems staggering (but I'm not 26 or 27 years old).

The number of loans on which there has been a default is remarkable—one, only one. Any banker would be envious. Obviously this speaks to the quality and character of the recipients.

Many Iowa physicians were either the recipients of these loans or had a friend that was. I am sure

we realize the importance of maintaining the capitalization of these funds. Dr. Seeböhm says we will be hearing more from him and his committee in the future. Let us respond generously when we do.

Those of you who attended the IMS Annual Meeting heard Dr. Richard Corlin speak. Dr. Corlin is vice speaker of the AMA House of Delegates and a gastroenterologist practicing in

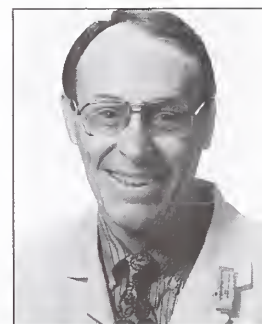
California. I am continually impressed by the high caliber of physicians who serve as trustees and officers of the AMA. They are capable, well informed and well spoken. Dr. Corlin made a comment about the *AM News*. If you are like me, about the last thing I need is one more journal or paper to read. However, he pointed out, the first four pages of *AM News* is particularly worthwhile reading to keep well informed.

He also stated very succinctly the two main current issues facing medicine and society; one, in what form and how will health care be delivered, and two, how will we be compensated. In California, he noted managed health care is dominant; in some areas 90 to 95% of the population is covered by this form of health care delivery system.

**The first
four pages of
AM News is
particularly
worthwhile
reading.**

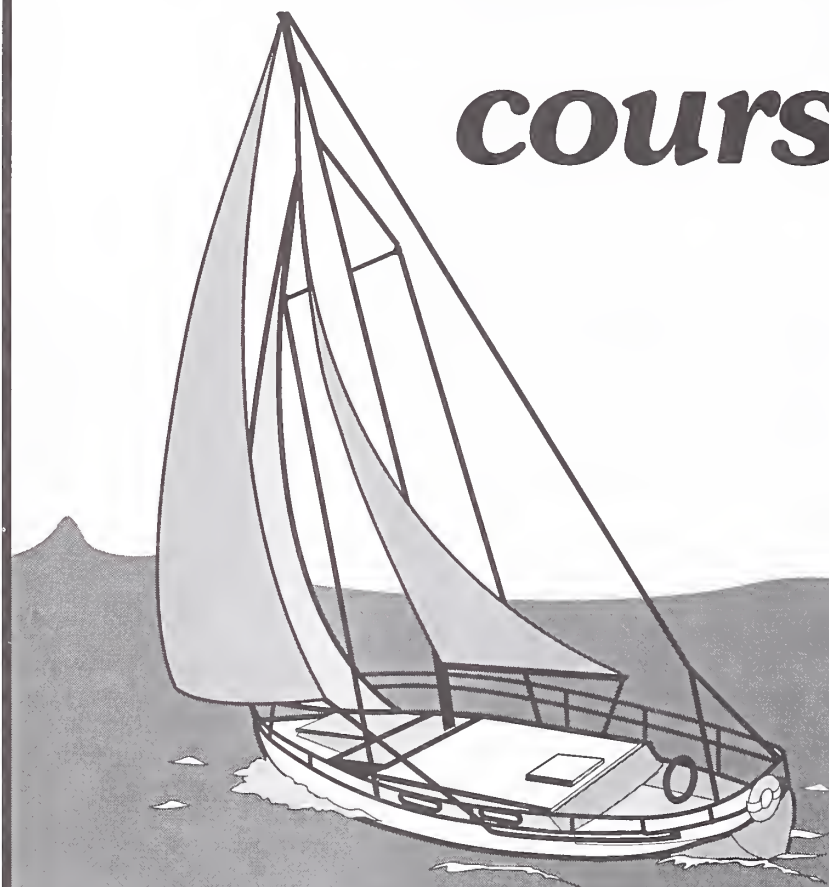
On May 24, the Board of Trustees met with the representatives of the Iowa Foundation for Medical Care. As instructed by the House of Delegates, we requested that next year we receive a report from them at our Annual Meeting. They will be pleased to do so. Unfortunately, poor communication was responsible for their absence this year.

We discussed the current approach of HCFA called Health Care Quality Improvement Program (HCQIP). This approach stresses quality improvement through education, sharing information among physicians and education of patients about their choices. Let's hope this is an improvement over past "medical care evaluation". **IM**



JOSEPH HALL, MD

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Your help is needed!

Next October, a major campaign will be initiated by the IMS to raise money for use by the IMS Education Fund.

This new fund-raising initiative is necessary because over the past 15 years the programs supported by the IMSEF have almost tripled, while contributions to the Fund have remained about the same.

Each year, approximately 450 IMS members make voluntary contributions amounting to \$22,000. There are also periodic contributions via memorial bequests and special donations from county societies and others. An annual income of approximately \$13,000 a year comes to the Fund from a special trust.

Although the payback to the medical student loan fund has been exemplary, the IMSEF has had to draw heavily on its reserves to meet the demands of ongoing and new programs. It is in need of an infusion of more monies into the system.

If you're unfamiliar with the fund, here's some background information:

- The IMSEF was created in the early 1950s. Included within its structure are the George H. Scanlon Medical Student Loan Fund, the Henry Albert Benevolence and Public Health Fund and a non-designated fund.

- The major activity of the Fund is the student loan program. In 1994-95, \$240,000 was loaned to 43 students. Since the inception of the program, over 800 loans amounting to \$2.7 million were awarded. Requests for loans—

both in numbers and amounts—are increasing every year. If there are additional cuts in federal financial assistance programs, the availability of private support will become even more important.

- In addition to loans to medical students, the IMS Assistance Program for Troubled Physicians receives support from the Fund, as does the IMS Scientific Session and *Iowa Medicine* (journal of the IMS.) Various public health education projects are also financed—e.g., child abuse identification, domestic violence, health care for the elderly, drug abuse and others.

There will be several ways you can give, and I urge you to begin thinking about how you will participate. In addition to tax-deductible cash gifts, there are various options for deferred

giving which allows the giver both a charitable tax deduction and a valuable donation, without forfeiting current needed income.

Several other IMS past presidents have joined me in the development of this fund-raising effort. These physicians are: Hormoz Rassekh, MD, Council Bluffs; Don

Rodawig, MD, Spirit Lake; John Tyrrell, MD, Manchester; and Dennis Walter, MD, Des Moines.

You'll be hearing from us! **IM**



PAUL SEEBOHM, MD

Dr. Seebohm is professor emeritus in the Department of Internal Medicine, UI College of Medicine in Iowa City. He is also chairman of the fund-raising committee for the IMS Education Fund.

In addition to tax-deductible cash gifts, there are various options for deferred giving.

IMS Update

AT A GLANCE

The American Medical Association is continuing its two-year Study of the Federation. John Rhodes, Jr., MD represents the IMS on the Consortium. Reportedly, Consortium participants generally support experimentation with changes in the structure of organized medicine.

The final death toll from the Oklahoma bombing was 167; 19 were children. Over 4,000 persons were injured, but few of those remain hospitalized. The attention of the medical community is now turning to the mental health of those involved in the tragedy.

IMS Directory verification letters due

July 14 is the deadline for returning your IMS member verification letter. The letter verifies member information for IMS records and the IMS Membership Directory. The letter was mailed to all physicians in early June.

The letter asks for information including practice address, telephone and fax numbers, clinic name, physician social security numbers and other information which will help IMS be more responsive to member needs.

This year, the letter also asks for the name of your senior clinic administrator.

It is important that you return your letter to ensure the correct information about your practice appears in this year's directory. The 1995-96 IMS Membership Directory will be distributed to all IMS physicians in October.

If you misplaced your letter or did not receive one, call Sheryal Westbrook or Sandy Nelson at the IMS, 515/223-1401 or 800/747-3070 to verify your information.

Specialty representation in IMS House

At the April IMS Annual Meeting, the House of Delegates approved a proposal to allow for representation for state specialty organizations in the IMS House of Delegates.

The IMS Board of Trustees is in the process of working out the details of that representation so that eligible state specialty organizations can apply for representation at the 1996 IMS House of Delegates.

Watch future issues of *Iowa Medicine* for further details.

IMS domestic violence video available

The Iowa Medical Society's 27-minute videotape "Break the Silence; Begin the Cure" on domestic violence is available for loan to any Iowa physician. Call Chris McMahon, IMS director of communications, at 515/223-1401 or 800/747-3070.

IMS cosponsors conference on aging

The IMS cosponsored the 1995 Governor's Conference on Aging held last month in Des Moines. The program was attended by over 550 people, including professionals who deal with programs for the elderly.

Eugene Lehrmann, president of the American Association of Retired Persons, was a guest speaker. He discussed the goals of AARP, emphasizing that AARP does not want to preserve programs for the elderly at the expense of their children and grandchildren and is working on solutions which do not unfairly burden succeeding generations.

SPECIALTY SOCIETY UPDATE

The IMGMA Spring Educational Meeting, held May 3-5 at the Des Moines Marriott, drew a record attendance of 310. Including exhibitors, there were 470 registrants. Fritz Wenzel, executive director of the Medical Group Management Association, was keynote speaker. The Executive Council is scheduled to meet July 11 in Des Moines. The Fall Meeting is September 13-15 at Lake Okoboji.

The Iowa Psychiatric Society has concluded negotiations with Medco Behavioral Health Corporation of Iowa for contracts with Iowa psychiatrists. The IPS was able to win several improvements in the contract. Call Dana Petrowsky for more information, 515/223-2816. The Executive Council will meet July 12 in Des Moines. The Fall Annual Meeting is scheduled for October 27-28 in Iowa City.

The American Medical Directors Association, Iowa Chapter, Spring Meeting was April 21. The program focused on depression and anxiety in the elderly.

Iowa Oncology Society President Dr. George Kovach and Dr. Dean Gesme attended the American Society of Clinical Oncology Annual Meeting in Los Angeles May 20-23. National practice standard guidelines and CPT coding were discussed.

The Executive Committee of the Iowa Pathology Association met June 15 at IMS headquarters. Discussions were held to contract with IMS Services, Inc. for staff support of the Association.

FOCUS ON IMS ALLIANCE

The IMS Alliance has completed another successful annual meeting. The basket auction for AMA Education-Research Fund raised \$2,277. A check for \$18,851 was presented to Dr. Robert Kelch, dean of the U of I College of Medicine.

The following IMS Alliance members were selected to serve as delegates to the AMA Alliance Annual Session of the House of Delegates in Chicago in June: Barbara Bell, Des Moines; Linda Miller, Davenport; Karen Messamer, Oskaloosa; Cindy Ehrecke, LeClaire; and Ann Crouch, Spencer. Kathy Beaty, Clive and Gretchen Graham, Iowa Falls, will attend as alternate delegates. I will report on this meeting next month.

I invite all medical spouses to our summer board meeting July 19-20 at Comfort Suites Living History Farms, Urbandale. Child care will be available. The meeting will focus on health promotion projects for the coming year. Patti Herlihy of Rapid City, SD will be our keynote speaker. She serves on the national health projects committee and will be discussing SAVE Today (Stop All Violence Everywhere), set for October 11, 1995.

Contributed by Linda Miller, president, IMSA

Red Cross seeks volunteers

The American Red Cross and the Des Moines Fire Department are organizing a voluntary team to provide support for Des Moines EMS services in the form of transportation to local hospitals for non-emergency patients and grief counseling to family and friends in the case of a death of natural causes.

The purpose of the program is to relieve the EMS team and hospital personnel so they are available for emergency calls. Any physician who knows someone who may be interested in this new program is urged to call Margie Conrad, American Red Cross director of volunteer services, 515/224-6700. **IM**

**July 14 is the
deadline for
returning your IMS
1995-96
Membership
Directory
verification letter.**

In the 1994 elections, IMPAC contributed over \$66,000 to 114 candidates running for state office. IMPAC contributed to 105 winners for a 92% success rate. Obviously, contributions from Iowa physicians were well spent.

But we cannot stop there. The 1996 elections are just around the corner. We cannot afford to let the interest of medicine be overshadowed by the banter of political rhetoric. The strides

made by IMPAC in 1994 must be sustained through 1996 if Iowa physicians are to be heard by their lawmakers.

If doctors abdicate responsibility to participate in the political process, it is certain that non-physician groups will take our place. They have already begun their fund-raising and grass roots work for 1996 and we cannot afford to fall behind now.

The time has come to step forward and be heard through a strong IMPAC.

Join IMPAC today!

**Here's where
the real
battles are
being
fought**



Futures

AT A GLANCE

Allen Health Systems, which includes Allen Memorial Hospital in Waterloo, plans to merge with Iowa Health System, which is composed of Iowa Methodist Medical Center, Iowa Lutheran Hospital (both in Des Moines) and St. Luke's Hospital in Cedar Rapids. This will give the new organization nearly 2,000 licensed beds and over 8,000 employees.

A coalition of central Iowa-based employers called the Community Health Purchasing Corporation (CHPC) recently held an informational meeting in Des Moines. The group is coordinated by the Health Policy Corporation of Iowa. The group supports a number of concepts, including increased purchaser/provider communication, fair and negotiated prices that reward appropriate care and consumer-driven competition.

PPRC recommends single conversion factor

Physician fees will be computed using only one update factor rather than three, if Congress accepts the Physician Payment Review Commission's recommendation. PPRC is recommending a single factor for primary care, surgical and non-surgical services.

PPRC also recommends a single fee update for all physician services for 1996 instead of separate updates for surgery, non-surgery and primary care.

Over the long term, PPRC wants Congress to change the method of adjusting the factor by using something similar to the gross domestic product instead of the volume performance standard.

In addition, they recommend using the conversion factor to adjust fees for budget neutrality rather than the relative value units.

People "crowding" into HMOs

The *Chicago Tribune* recently reported that people are crowding into HMOs and fleeing escalating costs of traditional fee-for-service health care, but once high-flying stocks of HMO companies have taken a dive.

Since March, the market value of HMO stocks has fallen 25%. As prices rise on everything from catheters to CAT scans and employers and insurers squeeze premiums, investors fear many HMOs could wind up on the financial critical list.

Most publicly traded HMOs remain profitable, but unpleasant earnings reports from several are seen as harbingers of hard times.

Also on the HMO front, a recent *Los Angeles Times* article questioned whether or not HMO physician reimbursement tactics jeopardize the quality and amount of care given to patients in medical need. The article cited a case in Simi Valley, California where a woman with abdominal pain and rectal bleeding was never tested by her doctor for serious medical problems.

Medicare fees recommendation

Donna Shalala, secretary of Health and Human Services, has recommended to Congress that physicians' fees be increased by 1.1% for all medical services in 1996. The update recommendation would require Congress to change the law covering Medicare's payments to physicians.

If Congress does not enact the recommendation, the default formula would go into effect resulting in estimated updates of a 3.9% increase for surgical services, a 2.2% decrease for primary care and a 0.6% increase for non-surgical services.

AMA trustee testifies on Medicare

"The Medicare program urgently requires serious, lasting change if its promise is to be preserved for current and future generations of Americans," Dr. Nancy Dickey, vice chair of the AMA Board of Trustees, told the Senate Finance Committee recently.

Dr. Dickey said three factors have pushed the Medicare program to its current "perilous point": demographics, new technology and the increased demand for a wide range of health services.

The AMA is proposing a new partnership in which patients, physicians, business and the government work together to develop rational and effective long-term solutions to Medicare's financing problems.

The AMA believes Medicare reform must adhere to five basic principles:

- Encourage beneficiary cost-consciousness.
- Increase price competition among providers.
- Reduce intergenerational inequity in financing.
- Test ways of reducing future generations' dependency on Medicare.
- Reduce regulatory and administrative complexity. **IM**



CHMIS *Update*

As part of the Iowa Medical Society's ongoing effort to educate Iowa physicians about the Community Health Management Information System (CHMIS), this CHMIS Update page will be a regular feature in *Iowa Medicine*.

IMS ACTIVITIES

Iowa Medical Society leadership and staff continue CHMIS activities and discussions of key CHMIS issues of concern to Iowa physicians.

Recently, in response to IMS inquiries, the CHMIS Governing Board confirmed that ERISA plans have been put on notice that they are expected to participate in CHMIS as of July 1, 1996. ERISA regulates self-insured plans. Everyone involved is hopeful they will voluntarily participate in order to gain the advantages of electronic billing and insurance verification for this group of patients.

Also, at its recent meeting, the IMS Board of Trustees discussed in detail the advantages of a single CHMIS network or multiple networks. The Board reaffirmed the House of Delegates position that multiple networks are in the best interest of physicians and the CHMIS. However, the Board acknowledged that there is dissenting opinion among some IMS members that a single network would be preferable. The Board will continue its close involvement in this and other CHMIS issues.

Finally, it was learned that the Hartford Foundation has approved another year of CHMIS funding.

CHMIS ADVISORY COMMITTEE ACTIVITIES

(IMS staff are observers at all advisory committee meetings and work groups.)

•Ethics and Confidentiality

This advisory committee continues work on a policy for release of data and identifying potential users of data. Generally, the policy protects patient-specific data as provided in CHMIS law, but does not protect provider-specific data.

•Technical Advisory

This advisory committee continues

work on the Request For Proposal (RFP) for the CHMIS data repository. The RFP is expected to be presented for approval by the CHMIS Governing Board in August. Data repository bidders will be given 30 days to respond; the Governing Board will award the repository contract in October or November.

This group has reviewed data elements to be collected in the repository and has struggled with how much storage will be needed. One difficulty is determining the number of providers who will eventually be involved with CHMIS and their volume of patient encounters.

It has been confirmed that insurance eligibility will be a Phase I activity, but will probably be limited to insurance information and not include status of deductibles and coinsurance.

Early indications are that Phase I will initially involve claims data only and encounter based information will evolve at a later date. It is anticipated that the data repository will store the results of the health status and consumer satisfaction surveys.

The Network Certification work group has been refining the Electronic Health care Network Accreditation (EHNAC) standards and has met with potential network vendors.

Also, the committee has decided networks would not be required to encrypt data as they carry out transfer responsibilities. The data repository would need to encrypt data. Data editing is best performed at the provider site.

YOUR representatives on state CHMIS committees:

CHMIS Governing Board:

Dale Andringa, MD
Des Moines
515/241-4102

Beth Bruening, MD
Sioux City
712/233-1529

CHMIS advisory committees:

**Communications/
Education**
Laine Dvorak, MD

Data Advisory
William Bonney, MD
John Brinkman, MD

Ethics/Confidentiality
Charles Jons, MD

Quality Review
Elie Saikaly, MD
William Langley, MD

Technical Advisory
Thomas Menzel, MD
Mark Purtle, MD

IMS CHMIS Committee:

Terrence Briggs, MD (chair)

IMS staff:
Barb Heck
Ed Whitver
Dean Gillaspay

Legislative Affairs

AT A GLANCE

GOP hopefuls are raking in campaign cash. Gramm has raised over \$8 million; Dole isn't far behind. Experts believe Dole will raise the most before next year's primaries.

The U.S. Senate is planning a probe of the American Association of Retired Persons. The main issue is the AARP's tax-exempt status and its unrelated business income.

A recent opinion piece in New York Newsday prompted a letter from AMA President Dr. Robert McAfee, who called the piece "ridiculous". The article alleged that liability reforms being considered by Congress would take away citizens' rights to have a case heard. The simple reason trial lawyers want things to stay as they are, said Dr. McAfee, is because they "walk away with \$333,000 of every \$1 million award."

Managed care for substance abuse

The state of Iowa is continuing its plan to implement managed care for Title XIX substance abuse cases. An RFP for contractors was released May 1. There have been two bidders on the contract — Iowa Health Systems (in partnership with Value Behavioral Health and Midwest Behavioral Management Services) and the National Council on Alcoholism and Other Drug Dependencies (in partnership with Medco Behavioral Care). Value Behavioral Health and Medco were bidders for the state's highly controversial mental health managed care contract.

Title XIX plans to implement managed care for substance abuse cases on September 1, 1995.

IMS among groups discussing PPA

The Iowa Medical Society continues to meet with large employers in Iowa to gain their support for the principles in the AMA's Patient Protection Act.

The IMS is part of a work group drafting a joint statement regarding patient and provider protections under managed care. The work group includes the IMS, the Iowa Hospital Association, Blue Cross and Blue Shield of Iowa, Principal Health Care of Iowa, SecureCare, Heritage National Healthplan and John Deere Family Health Plan.

The group recently finished its second draft. This draft has been approved by the IMS Board of Trustees, pending approval by other groups. Watch future issues of *Iowa Medicine* for the full text of the agreement as soon as it is finalized.

Other states have chosen to pursue legislation based on the Patient Protection Act rather than the voluntary approach taken by the Iowa Medical Society and other organizations. However, according to a recent article in the *Wall Street Journal*, states which have

CONTACTS NEEDED WITH STATE SENATORS BEFORE NEXT SESSION

The IMS will continue to push for the reduction in the statute of limitations for minors in the 1996 Iowa Legislature. An IMS-proposed bill passed the House this session and has been assigned to the Senate Judiciary Committee. This means it remains alive for 1996. Physicians are strongly encouraged to spend time with their senators before the next session of the Iowa Legislature and help them understand how important this reform is to them and their patients.


attempted to enact the Patient Protection Act as legislation have been less than successful.

Meanwhile, the AMA continues to push for enactment of the Patient Protection Act at the federal level. Dr. Lonnie Bristow, president-elect of the AMA, said in a recent interview that without the Patient Protection Act, administrators — not doctors — of health maintenance organizations are setting standards of patient care.

Health care access rules finalized

The Iowa Insurance Division has completed the process of promulgating administrative rules to implement legislation requiring that employers provide access to health insurance coverage. This law became effective January 1, 1995.

Beginning May 1, 1995, any employer doing business in Iowa who does not provide health insurance to employees shall provide to their regular full time or regular part time eligible employees a written referral of where those employees can get information on health care. This written referral can be to a health insurance agent, health insurance carrier or other health care organization.

Temporary employees, independent contractors and minors are not included in the list of eligible persons. 

Medical Economics

Physicians provide "billions" in free care

More than two-thirds of American physicians are providing over \$21 billion in uncompensated care to patients in financial need, according to a report released by the American Medical Association.

According to the AMA's survey report, 307,650 physicians rendered over \$11 billion in charity or reduced-fee care to patients in need during 1994 and absorbed an additional \$10 billion in services for which payment was expected but never received.

Since 1988, AMA surveys have shown a steady increase in the number of physicians providing charity care and the amount of time physicians spend per week rendering free or reduced-fee care.

Across 10 specialty classifications, percentages of physicians who provide charity care ranges from 60% to 74%. Surgeons and radiologists most frequently provide charity care. Rural or nonmetropolitan physicians provide charity care more frequently (71%) than urban physicians (67% to 68%).

Medicare claims processing conversion

Conversion to a new system of Medicare claims processing for Iowa physicians has reportedly gone smoothly.

However, there have been a few changes as a result of the conversion. With the old system, Medicare was able to change modifiers that had been used incorrectly to expedite the claim payment. The new system is not as forgiving and Medicare must stay with standardized processing, which means claims must be exact.

Some physician offices have reported that the remittance notice is difficult to read because of small print. Medicare is confident this problem can be improved.

A special MedInfo was mailed to all physician offices regarding the results of the conversion. If your office has problems, call Mary Reinsoen at the IMS.

Preventive services on endangered list

Experts in preventive medicine fear that some time-honored aspects of the annual physical will soon be extinct.

An article entitled "Death of the Physical" in a recent issue of *LACMA Physician* said the following procedures are at special risk since they have not been scientifically shown to have significant benefits:

- Checking reflexes — Pertinent only for patients with low back pain or other neurological symptoms.

- Routine ECG — Necessary only in some cases, for example, men 40-64 with two or more cardiac risk factors.

- Chest x-rays — Chances of positively affecting outcome if an abnormality is discovered are slim.


- Auscultation of lungs — Even for those aged 65 and over, it isn't recommended.

- Complete blood panel — Only nonfasting blood cholesterol, dipstick urinalysis and thyroid function test (for women) are recommended.

President proposes less paperwork

President Clinton wants to get ahead of congressional deregulation and help reduce paperwork for small businesses, according to a recent *Kiplinger Newsletter*. He wants to get credit for helping small businesses by ordering agencies to trim fines for minor violations and cut the number of reports which must be filed.

The FDA will no longer require environmental assessments of drugs by manufacturers or premarketing evaluations of new medical devices that pose little risk. OSHA will cut penalties 70% for firms with good safety records and will cease nit-picking such as \$400 fines for not displaying posters.

Deregulation is usually proposed every 10 years but bogs down due to court challenges and "foot-dragging bureaucrats who demand more reports" says *Kiplinger*. 

AT A GLANCE

Tobacco industry efforts to turn back county-wide anti-smoking ordinances in Wichita Falls, Texas were defeated at the ballot box by the concerted efforts of the Wichita County Medical Society, the Texas Medical Association and the AMA.

A recent Washington Post article discussed the "rancorous debate" that surrounded medical liability reform legislation in the House and Senate, alleging that participants reached new heights in the art of influencing politicians. As an example, the article singled out the AMA's Dr. Maureen O'Regan ads. Ironically, the Post reprinted the AMA's full-page ad juxtaposing nine Surgeons General and Health Secretaries of both parties all urging caps on non-economic awards.

HMO

MEDICAL DIRECTOR

Community Health Plan is a non-profit community owned HMO, being developed throughout Northwest MO. We currently seek a half-time Medical Director. If you can continue to practice half-time and have managed care administrative background (prefer HMO management experience), you should consider Community Health Plan in St. Joseph, MO. Use your extensive communication, leadership, and clinical skills. This position is responsible for the day-to-day clinical review activities of the Plan, medical care delivery model development, chairing several physician committees, and assisting our providers in our communities with education and support for our managed care activities.

Send resume to **Community Health Plan**, 5301 Faraon, St. Joseph, MO 64506, Attn: Joan Copeland or call 800-990-9247.



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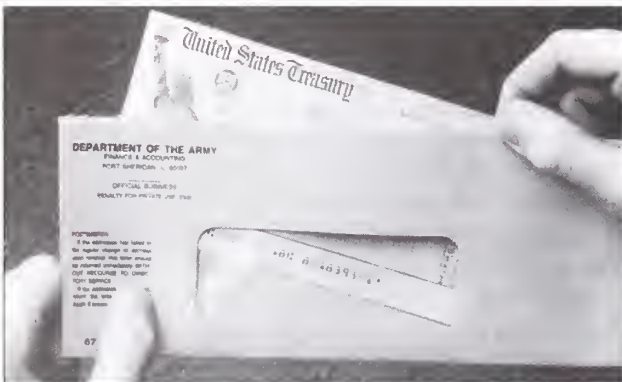
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MSM
Gary Nielsen, CPA

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Practice Management

New guidelines for CPT coding

Through July 31, 1995, Iowa's Medicare carrier will be phasing in implementation of new CPT coding guidelines. Beginning August 1, evaluation and management (E/M) codes will no longer be excluded from the Medicare medical review system. Carriers will vary in their timetables for utilizing the guidelines in reviewing E/M services.

If evaluation and management review is indicated, carriers will request medical records for specific patients and encounters. The documentation guidelines will be used as a template for that review. If the documentation is not sufficient to support the level of service provided, the carrier will contact the physician for additional information.

Remember, the documentation guidelines do not equate to medical necessity review, which is a separate determination by the carrier. Medical necessity review may occur after the carrier determines that the service was rendered but not reported correctly.

Review of evaluation and management services will occur only if evidence of significant aberrant reporting patterns is detected (based on national, carrier or specialty profiles).

All reviews are conducted on a "focused" basis — there is no random review.

For more information on the new guidelines, call Barb Heck or Mary Reinsmoen at the IMS, 515/223-1401 or 800/747-3070. **IM**

MIDWEST MEDICAL INSURANCE COMPANY Focus on Risk Management

Telephone advice

In most clinics, a great deal of advice is given to patients over the telephone. Many patient injuries and malpractice claims have resulted from incorrect diagnoses and treatments based on information obtained over the telephone without benefit of a clinical examination. To reduce your liability risks:

- Allow only physicians or trained staff to handle telephone advice calls.
 - Establish telephone triage guidelines that outline how calls should be handled.
 - Advise patients of the limitations of telephone treatment and tell patients to call back if their condition changes.
 - Document all telephone advice calls in the patient's medical record.
 - Ensure triage guidelines were followed by reviewing staff documentation of advice calls.
- One common problem many physicians face involves how to ensure adequate after-hours documentation of telephone advice. Recommendations include:
- Use telephone message forms.
 - Dictate telephone encounters immediately.
 - Use office voice mail to dictate after-hours advice calls.

For further information, contact Lori Atkinson, MMIC risk management coordinator, MMIC West Des Moines office, PO Box 65790, West Des Moines, Iowa 50265, 800/798-9870 or 515/223-1482.

AT A GLANCE

Medical Computer Management, Inc. has merged with CUSA Technologies of Salt Lake City. The merger brings additional benefits to MCMI customers in Iowa who have the AMOS computer system.

Don't miss the feature story in this month's Iowa Medicine, which discusses changes to Iowa's organ donation laws and Iowa laws on living wills and durable power of attorney for health care.

PRACTICE MANAGEMENT WORKSHOPS FOR YOU

QUALITY IN THE MEDICAL OFFICE

Wed., Sept. 6

Sioux City

Wed., Sept. 20

IMS headquarters

Wed., Sept. 27

Burlington Medical Center

This course examines trends in quality including outcome measures and practice parameters.

For more information or to register for any IMS practice management workshop, call Mary Reinsmoen or Sherry Johnson at IMS Services, 515/223-2816 or 800/728-5398.

IMS Services staff will present any of our practice management seminars to individual clinics and physician offices for a discounted price. Call Mary Reinsmoen at IMS Services for more information.

Newsmakers

AT A GLANCE

A partnership between the UI Health Science Center, Iowa City, and St. Petersburg Medical Academy of Post-graduate Studies in Russia will bring U.S. style of family practice medicine to Russian physicians. A two-year program will train future Russian teachers in the principles and practice of family medicine. Five Russian physicians will spend six months training in the U.S. at the UI Department of Family Practice.

At the May meeting of the Iowa State Board of Health, Iowa's new state epidemiologist, Dr. Patty Quinlisk, reported on an outbreak of Legionnaire's disease in Burlington. Three cases were identified; two guests and one employee of a local hotel. The CDC investigation found no physical evidence of bacteria present at the hotel.

Awards, appointments, etc.

Dr. Ross Madden, Dubuque, was recently named Internist of the Year by the Iowa Clinical Society of Internal Medicine. This award was given to Dr. Madden who demonstrated outstanding service to community, academia and state/national medical organizations. **Dr. Patricia McGuire**, Cedar Rapids pediatrician, has been appointed by Governor Branstad to the Iowa Council on Early Intervention. Dr. McGuire will serve on the council for two years. **Dr. Jack Spevak**, retired Des Moines pediatrician, received an honorary Doctor of Science degree at Grand View College commencement exercises for his "generous sharing of self, pursuit of knowledge and skill and service to humanity through pediatric medicine." **Dr. Jill Hunt** has joined Finley Hospital's ER/Trauma Department in Dubuque. **Dr. George York**, Clinton family practitioner for 35 years, received the Mount St. Clare College Award at recent commencement exercises. Dr. York was cited for his distinguished service to the community. **Dr. John Viner**, internist and infectious disease specialist at Dubuque Internal Medicine, recently received the Laureate Award of the Iowa Chapter of the American College of Physicians. **Dr. R. Bruce Bedell**, medical director of Care Choices HMO, Sioux City, has been named a diplomate of the American Board of Medical Management, the national certifying agency for physician executives. **Dr. Ian Koontz** has begun practice with Dubuque Internal Medicine.

New members

Algona

William Parker, MD, family Practice

Ames

Steven Sheldahl, MD, family practice

Ankeny

Nancy Akins, DO, family practice

Boone

David Kermode, DO, general surgery

Cedar Rapids

David Bittleman, MD, internal medicine

Alvina Driscoll, MD, obstetrics/gynecology

Jill Flory, MD, resident

Karen Harmon, MD, resident

Kirk Kilburg, MD, resident

Wieslaw Machnowski, MD, pediatric gastroenterology

Donald Marquardt, MD, family practice

Daniel McGrail, MD, internal medicine

Steven Paulsrud, DO, resident

Mary Pruzinsky, MD, otolaryngology/head & neck surgery

Douglas Purdy, MD, internal medicine

William Renk, MD, pediatric adolescent medicine

Stephen Runde, MD, family practice

Jana Serbousek, MD, resident

Gregory Skopec, MD, obstetrics/gynecology

Ronald Weichert, MD, resident

Timothy Winters, MD, resident

Clinton

Lane Williams, MD, obstetrics/gynecology

Justice Gondwe, MD, internal medicine & infectious diseases

Corning

Bethel Kopp, MD, internal medicine

Davenport

Steven Aguilar, MD, resident

Janice Baker, DO, anesthesiology

William Benevento, MD, ophthalmology

Brenda Brown, MD, resident

Shobha Chitneni, MD, internal medicine

William Davidson, MD, gastroenterology

Shane Kasner, MD, resident

Jill Kimm, MD, neurology

Joanne Miller, MD, resident

Michael Phelps, MD, general surgery

Janet Ryan, MD, resident

Benjamin Van Raalte, MD, plastic & hand surgery

Decorah

Gregory McAnulty, MD, family practice

Des Moines

Laurie Ballew, DO, resident
Wayne Belling, DO, family practice
Douglas Brenton, MD, neurology
James Coggi, MD, pediatrics
Steven Dawson, MD, pediatrics
Victoria Dietz, MD, resident
Dominic Frecentese, MD, radiology
Samuel Gardner, DO, resident
Ben Gaumer, DO, family practice
Joel Gordon, MD, resident
Ross Huffman, DO, resident
Lori Lynner, MD, resident
Celeste Miller, MD, resident
Kirk Peterson, MD, resident
Timothy Raligh, DO, resident
Chaudri Rasool, DO, resident
Thomas Reinbold, DO, resident
James Seabert, MD, family practice
Romeo Smith, MD, resident
Dale Steinmetz, MD, resident
Amanda Troutman, DO, resident
William Watson, DO, resident
Mark Weber, MD, resident
Robert Williams, MD, medical oncology

Dubuque

Barry Blyton, MD, radiation oncology
Joseph Compton, MD, internal medicine
Laurie Garms, MD, neurology
David Houlihan, MD, psychiatry
Margaret Mulderig, MD, physical medicine & rehabilitation
John Stecker, MD, psychiatry
Grant Westenfelder, MD, infectious diseases

Fort Dodge

John Edeen, MD, orthopedics

Iowa City

David Boysen, MD, dermatology
Timothy Gibbons, MD, orthopedics
Scott Graham, MD, otolaryngology
Robert Kelch, MD, pediatric endocrinology
Karen Maves, MD, internal medicine
Nina Mayr, MD, radiation therapy
John Mehegan, MD, cardiology
Brian O'Meara, MD, gastroenterology
Andrea Struss, MD, psychiatry

Deceased member

James McMillan, MD, 78, life member, radiology, Des Moines, died April 18 

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Death, dying and IOWA LAW

When has enough medical care been given and when should nature be left to take its course? As medical science and technology have advanced, what is in the best interests of the patient is not always easily ascertained. This article reviews Iowa law relating to end-of-life issues.

Physicians face death and dying more directly than the rest of us. Your professional lives revolve around helping your patients to stay or get well and to comfort those whose lives are ending.

The impending death of my 93-year-old grandmother brought home these issues to me last year. After a long life of doing things for herself it was difficult for my grandmother herself and my uncle, who lived down the hill from her all his adult life, to face the fact that since 24-hour in home nursing care was not feasible on her isolated northwest Missouri farm, the next best option was a nursing home in Prairie City, Iowa, a few miles from my parents' farm.

After moving to the nursing home, her disease was diagnosed. Active treatment would likely have done more harm than good so she continued to live in the nursing home. Eventually she stopped eating much, developed pneumonia and was hospitalized, apparently unconscious. The family faced the decision of whether to provide nutrition through a stomach tube.

I was in the hospital visiting when the surgeon came in to talk to my mother about the options (my uncle had gone home with

the flu). I was impressed with how simply and clearly he outlined the pros and cons of providing artificial nutrition and explained the discussions of the hospital's ethics committee. He made it clear the decision was up to the family but there were risks involved with surgical insertion of the feeding tube. She wasn't going to get better. He was compassionate but didn't mince words.

Time stopped and my brain seemed to shut off while he was talking. Even with the absolute clarity of his words my conscious mind simply didn't want to comprehend the message. Even though my grandmother, tiny in her hospital bed, her breath rattling from pneumonia, was not the same active person she had been in my childhood when she shooed us all outside to play, and even though she was 93 and her death was not unexpected, it was difficult to accept.

Later, after the doctor had answered our questions and left the room, it seemed the same thing had happened to my mother. By reconstructing the doctor's clear and simple statements we understood that what he was telling us was that my grandmother was dying. We had the choice of letting it happen

Even with the absolute clarity of his words, my conscious mind didn't want to comprehend the message.



BECKY ROORDA

Ms. Roorda is manager of public affairs at the IMS and has been involved in legislative affairs for 15 years.

HERE'S TO YOUR

Health

A patient's guide to better health
Provided by the Iowa Medical Society

Organ & Tissue Donation

DONOR CARD

This is a legal document under the Uniform Anatomical Gift Act or similar laws, signed by the donor and the following two witnesses in the presence of each other.

Donor's signature

Donor's date of birth

City & State

Witness

Witness

Next of kin

Telephone

Please type or print full name of donor

In the hope that I may help others, I hereby make this gift for the purpose of transplant, medical study or education, to take effect upon my death.

I give:

- ☐ Any needed organ/tissues
☐ Only the following organs/tissues

Specify the organ(s)/tissue(s)

Limitations or special wishes if any

Who can become a donor?

Everyone should consider himself or herself a potential organ and tissue donor. Anyone over the age of 18 can indicate their desire to be an organ donor by signing a donor card or expressing their wishes to family members. Relatives can also donate a deceased family member's organs and tissues, even those family members under the age of 18.

Donation of heart, liver, lung, pancreas or heart/lung can occur only in the case of brain death. Brain death occurs when a person has an irreversible, catastrophic brain injury which causes all brain activity to stop permanently. Donation of tissues such as bone, skin or corneas can occur regardless of age and in almost any cause of death. Your medical condition at the time of death will determine what organs and tissues can be donated.

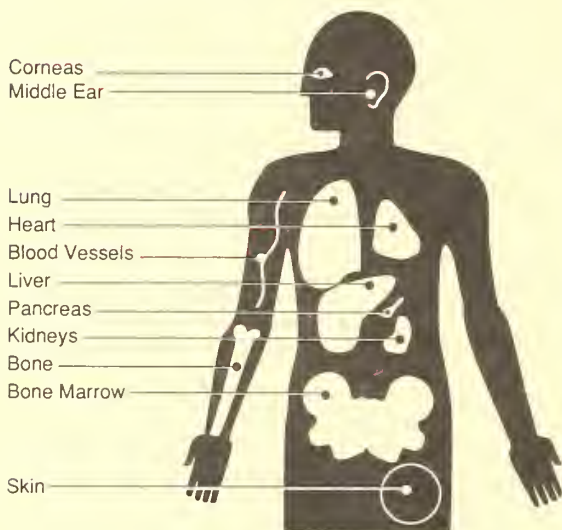
How do I become a donor candidate?

Fill out a donor card and carry it with you in your wallet or purse. A sample card (front and back) appears at left. Actual cards may also be obtained through the Iowa Statewide Organ Procurement Organization (call 1/800-831-4131) or your local driver's license station.

Most states have a way you can use your driver's license to indicate your desire to be a donor. In Iowa, a box appears in the right hand bottom corner on the front side of the license. In that box you may indicate a "Y" to donate your organs or tissues.

It is also extremely important that you let your family know you want to become a donor at the time of your death. Ask family members to sign your donor card as witnesses. When you die, your next of kin will be asked to give their consent for you to become a donor. It is very

ORGANS AND TISSUES FOR TRANSPLANTATION



important they know you want to be a donor because that will make it easier for them to follow through on your wishes. It would also be useful to tell your family physician, religious leader and attorney about your wishes. You may also want to indicate in your will that you wish to be an organ/tissue donor.

What If I change my mind about donating my organs or tissues?

If you change your mind, tear up your donor card. If you indicated your willingness to donate on your driver's license, cross out that section on your license. Be sure to let your family know of your decision.

Are there religious objections to organ/tissue donation?

Most major religious groups in the U. S. approve and support the principles and practices of organ/tissue donation. Transplantation is consistent with the life preserving traditions of these faiths. However, if you have any doubts, you should discuss them with your spiritual leader.

Will the quality of hospital treatment and efforts to save my life be lessened if staff know I am willing to be a donor?

No. A transplant team does not become involved until other physicians involved in the patient's care have determined that all possible efforts to save the patient's life have failed.

Does organ donation leave the body disfigured?

No. The recovery of organs and tissues is conducted in an operating room under the direction of qualified surgeons and neither disfigures the body nor changes the way it looks in a casket. A traditional, open casket funeral service can still take place even though many organs and tissues have been donated.

Is it permissible to sell human organs?

No. The National Organ Transplant Act prohibits the sale of human organs. Violators are subject to fines and imprisonment. Among the reasons for this rule is the concern of Congress that buying and selling of organs might lead to inequitable access to donor organs with the wealthy having an unfair advantage.

What are the steps Involved In organ donatlon and transplantatlon?

1. A potential donor who has been diagnosed as brain dead must be identified.
2. Next of kin must be informed of the opportunity to donate their relatives' organs and tissues and must give their permission.
3. An Organ Procurement Organization is contacted to help determine organ acceptability, obtain the family's permission and match the donor with the most appropriate recipient(s).
4. Organ(s) and tissue(s) are surgically removed from the donor.
5. The donor organs and tissues are taken to the transplant center(s) where the surgery will be performed.

When a potential organ donor is identified by hospital staff and brain death is imminent or present, an organ procurement organization (OPO) is contacted. The OPO is consulted about donor acceptability and often asked to counsel with families to seek consent for donation. If consent is given, a search is made for the most appropriate recipient(s) using a computerized listing of transplant candidates managed by the United Network for Organ Sharing which operates the National Organ Procurement and Transplantation Network.

It is increasingly common for donors and donor families to contribute multiple organs and/tissues. Therefore, several recipients may be helped by a single donor. When a match is found, the OPO will arrange for the donated organ(s) to be surgically removed, preserved and transported to the appropriate transplant center(s). A potential recipient(s) is also alerted to the availability of an organ and asked to travel to the transplant center where he or she is prepared for surgery. The recipient's diseased or failing organ is removed and the donated organ is implanted.

How are reciplents matched to donor organs?

Persons waiting for transplants are listed at the transplant center where they plan to have surgery and on a national computerized waiting list of potential transplant patients in the U.S. When donor organs become avail-

DID YOU KNOW?

- There are **129** lowans waiting for a kidney transplant
- There were **163** kidney transplants performed in Iowa in **1994**
- There are **12** lowans waiting for a liver transplant
- There were **39** liver transplants performed in Iowa in **1994**
- Nationally, almost **25%** of all individuals awaiting liver transplants are **10** years old or younger
- The number of transplantations has nearly doubled since **1983**, due primarily to dramatic increases in the number of individuals awaiting transplants
- Nationally, there are **39,693** individuals needing transplants—**16,708** females, **22,985** males

able, several factors are taken into consideration in identifying the best matched recipient(s). These include medical compatibility of the donor and potential recipient(s) on such characteristics as blood type, weight and age; urgency of need; length of time on the waiting list and distance from the donor site to the recipient transplant center. Usually donors from Iowa get transplanted into Iowa recipients here first because timing is a critical element in the organ procurement process. If a suitable recipient for a particular organ cannot be found in Iowa the organ is offered out to the rest of our region. If there is no suitable recipient in our region the organ is offered nationally. Hearts can be preserved for up to six hours, livers up to 24 hours and kidneys for 72 hours. Lungs cannot be preserved outside the body for any extended period of time.

Transplant teams consisting of ethicists, social workers, nurses, procurement personnel and physicians alike are always re-evaluating the methods which aid in the determination of organ allocation.

Why should minorities be particularly concerned about organ donation?

Minorities suffer end-stage renal disease (ESRD), a serious and life-threatening kidney disease, much more frequently than do whites. Asian Americans are three times more likely than whites to develop ESRD; Hispanics are three times as likely and blacks are twice as likely as whites to develop ESRD.

As with any transplant procedure, it is very important to assure a close match between donor and recipient blood type and genetic make-up. Members of different racial and ethnic groups are usually more genetically similar to members of their own group than they are to others. (For example, blacks are usually more genetically similar to other blacks than they are to whites.) It is important, therefore, to increase the minority donor pool so good matches can be made as frequently as possible for minority patients.

This information on organ/tissue donation and transplantation has been provided by the Iowa Statewide Organ Procurement Organization. As a service to IMS member physicians, this insert may be photocopied for placement in clinic reception areas. Original inserts may be purchased from the Iowa Medical Society for 15 cents each. Call Jane Nieland or Bev Corron at the IMS, 515/223-1401 or 800/747-3070.

naturally fairly soon or prolonging it for awhile. After discussing it with my uncle who had early on favored life prolonging measures, my mother and he both agreed that the kindest thing, and what my grandmother probably would have wanted, was to let her go. She died in the hospice a week later.

What is the message in this? No surprise to most physicians, this decision-making process worked well because the choices were clear and there were family members available who could agree on the best course of action and the desires of my grandmother.

When this is not the case — and even sometimes when it is — assistance may be needed. Legal instruments in the form of living wills and durable powers of attorney for health care are recognized in Iowa through the efforts of the Iowa Medical Society working with the Iowa Hospital Association and the Iowa State Bar Association. These documents provide a legally recognized way to provide advance guidance to family members, friends and physicians when the individual is no longer able to make health care decisions.

Iowa's Uniform Anatomical Gift Act allows an individual to make a decision to donate tissues and organs, relieving family members of the decision at an emotional time.

LIFE-SUSTAINING PROCEDURES ACT

Iowa's Life-sustaining Procedures Act was passed in 1985 as an initiative of the Iowa Medical Society and other groups. The Act provides that a competent adult may execute a living will and provides procedures for doing so.

A living will is a document that directs that life-sustaining procedures be withheld or withdrawn if the individual's condition is terminal and the individual is unable to make treatment decisions. A living will is not legally binding if these conditions are not

met. Determination that the condition of the individual is terminal must be made by two physicians with that determination recorded in the medical record.

The living will must be signed by the individual or a person acting on behalf of the individual at the individual's direction, must be dated and must be either witnessed by two adults who are not health care providers (or employees) of the individuals or notarized.

It is the responsibility of the individual to provide the attending physician or other health care provider with a copy of the living will. The physician may presume that the declaration complies with the law and is valid unless actually notified to the contrary. A living will may be revoked at any time either orally or in writing.

Legal issues

A living will is a legally binding document. If the patient is unable to make decisions and a living will is in existence, physicians and other health care providers are required to follow the terms of the document. Physicians who are unwilling to participate in the withholding or withdrawing of life-sustaining procedures are not required to do so.

However, they are required to take reasonable steps to transfer the patient to another physician if the patient has a living will or if in the absence of a living will a determination is made by one of the listed decisionmakers following the procedures outlined in the law.

Immunities

The law specifically provides that physicians, persons acting under a physician's direction and hospitals are not subject to civil or criminal liability or guilty of unprofessional conduct for acting in accordance with the Life-sustaining Procedures Act unless actually notified of the revocation of a living will. Compliance with

continued

Want more information?

For brochures about Iowa's advance directives including living will and durable power of attorney for health care, call Bev Corron at the Iowa Medical Society.

For single copies of forms for living wills and durable power of attorney for health care, patients should send a stamped, self-addressed envelope to: Iowa State Bar Association, 521 E. Locust, Des Moines, IA 50309.

For more information on organ donation, including organ donor cards, call the Iowa Statewide Organ Procurement Organization, 800/831-4131.

What about legal immunities?

Physicians, hospitals, physician assistants, technicians, enucleators, medical examiners and others who comply or attempt to comply with the Uniform Anatomical Gift Act in good faith or with another applicable state law are immune from civil or criminal liability which might result from making or accepting an anatomical gift. An individual who makes such a gift or the estate is not liable for any injury or damages that may result from the donation if made in good faith.

the Act is an absolute defense if civil or criminal liability is asserted.

DURABLE POWER OF ATTORNEY FOR HEALTH CARE

A durable power of attorney for health care is another form of advance directive legally recognized in Iowa. A durable power of attorney for health care authorizes an individual, the "principal", to designate another individual, the "attorney in fact", to make health care decisions for the principal when the principal is unable to do so.

Requirements

An attorney in fact may make health care decisions only if explicitly authorized by the durable power of attorney for health care, the durable power of attorney for health care is dated and correctly witnessed or notarized, and the attorney in fact is not a health care provider attending the principal or an employee of the health care provider. The attorney in fact may be any other person designated to make decisions, such as a trusted friend or relative.

The attorney in fact has priority over all other individuals in making health care decisions for the principal if the principal is unable to make those decisions, including the decision to withhold or withdraw health care.

The attorney in fact has a duty to act in accordance with the desires of the principal as expressed in the document or otherwise made known.

If the desires are unknown the attorney in fact has a duty to act in the best interests of the principal, considering the principal's overall medical condition and prognosis.

Revocation

Like a living will, a durable power of attorney for health care may be revoked at any time and in any manner without regard to the mental or physical condition of the principal. The revocation is in effect for a health care provider only when the health

care provider is notified. Documentation of the revocation should go in the medical record.

Immunities

As with a living will, a health care provider is not subject to criminal prosecution, civil liability or professional disciplinary action for acting in good faith. A health care provider is not required to participate in the withholding or withdrawing of health care necessary to keep the principal alive but the attorney in fact may transfer the responsibility for the care of the principal to another health care provider. An attorney in fact is similarly protected for decisions made in good faith.

Iowa's advance directive laws are designed to provide a way for a patient to deal with health care decisions, including the issue of life-sustaining care, in advance. Physicians are encouraged to discuss these issues with patients while they are able to make decisions.

This is simply a brief overview of Iowa's laws relating to advance directives and organ donation and should not be considered legal advice. Physicians may wish to consult with legal counsel when dealing with specific cases.

UNIFORM ANATOMICAL GIFT ACT

Iowa's Uniform Anatomical Gift Act was adopted in 1971 to provide a legally recognized way for individuals to make a decision in advance to donate bodily organs.

In 1994, the Iowa Statewide Organ Procurement Organization (ISOPO) approached the IMS with a draft of a new version to update the law to recognize the many changes in the field of organ transplantation that have occurred since then. The IMS, the Iowa Hospital Association

and the Iowa State Bar Association all worked with ISOPO to review and refine the draft legislation. The result was Senate File 117 which went into effect July 1, 1995.

Who may donate

Any competent individual who is at least 18 years old may donate an organ. The new law also allows a minor at least 14 years old to make the decision to donate with the written consent of a parent or legal guardian. Such individuals may also legally make the decision not to donate. If an individual has not made a decision not to donate, the following individuals may donate organs or tissues on behalf of the decedent in order of precedence: the attorney in fact pursuant to a durable power of attorney for health care, the decedent's spouse, an adult child, a parent, an adult sibling, a grandparent or a guardian at the time of death.

How to donate

An individual may make an organ donation by signing a "document of gift" which may be a specific donor card, a uniform donor card, a will or any other written document executed to meet the provisions of the law. Indication on a driver's license of the desire to donate is also recognized as expressing the individual's intent; prior to enactment of the new law the driver's license designation had no legal meaning. The document of gift may indicate that the individual wishes to donate the whole body or only specified body parts. The document of gift may be changed or revoked by the individual donor at anytime before death. A valid document of gift executed by the donor may not be revoked by any other person.

Who may receive

An individual may designate any of the following as the donee:

1. A hospital, physician, organ procurement organization, or bank or storage

organization for transplantation, therapy, medical or dental education, research, or advancement of medical or dental science.

2. An accredited medical or dental school, college, or university for education, research, or the advancement of medical or dental science.

An anatomical gift may also be made without designating a donee, in which case any of the listed entities may accept the gift.


What should be done with the document of gift

The law allows an individual to keep the document of gift or to deliver the document to the designated donee. It is also recommended that copies be made available to persons who may need to know about them such as close family members or an attorney in fact if a durable power of attorney for health care has been executed. A document of gift or a copy may be deposited in any hospital, organ procurement organization band or storage organization, or registry office that accepts the document of gift for safekeeping. Upon the death of the donor the entity in possession of the document may allow the hospital or physician to examine or copy the document to include in the records.

Examination

The body part may be examined or tested for HIV or communicable diseases to ensure medical acceptability of the gift.

Autopsy

The body may be autopsied pursuant to other state laws. 

What if there is no advance directive?

If a person has no living will or other form of advance directive, the law provides that life-sustaining procedures may be withheld or withdrawn from a patient who is in a terminal condition and who is comatose, incompetent or otherwise physically or mentally incapable of communication. To do so, there must be agreement between the attending physicians and one of the following in order of priority:

1. The attorney in fact designated to make treatment decisions for the patient
2. A court-appointed guardian if one has been appointed
3. Spouse
4. Adult child (or a majority of adult children)
5. A parent
6. An adult sibling

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The Journal

of the Iowa Medical Society

Latex allergy

● RK AGARWAL, MD; A AL-SHASHI, MD

A 28-year-old dentist had eczema of both hands which got better after he discontinued wearing latex gloves. He occasionally coughed and sneezed in the office. He underwent an appendectomy under spinal anesthesia but developed unexplained profound hypotension within 10 minutes of the abdominal incision. Evaluation post-operatively showed him to have IgE antibodies to latex proteins.

This case history demonstrates the emerging problem of IgE sensitization to latex. Over the last five years, the FDA has received over 1,100 reports of injury and 15 deaths associated with latex allergy. This is not to be confused with Type IV hypersensitivity (contact dermatitis) to rubber.

Type I reactions

Natural rubber (Cis-1,4 polyisoprene) is a processed plant product, derived from the milky sap of the plant called *Hevea Brasiliensis*. The type I reactions occur in response to protein allergens which surround the cis-1,4 polyisoprene particles while type IV hypersensitivity occurs to rubber additives like mercaptobenzothiazole, tetramethylthiuram and other chemicals which serve as accelerators and antioxidants. Most patients with type IV hypersensitivity do not have type I or IgE mediated allergic reactions. It is possible to have type I hypersensitivity without associated type IV hypersensitivity. There is some evidence that continued use of natural rubber or latex product in patients with allergic contact eczema to latex might increase the likelihood of developing IgE sensitization.

Route of exposure

Immediate hypersensitivity reactions have

been elicited by exposure to rubber gloves, condoms, barium enema or bladder catheters, balloons, toys, dental prophylaxis cups and sports equipment. Gloves are of major importance because of their frequent use. A person could be exposed to the allergen via skin; oral, vaginal, rectal or urethral mucosa; or parenteral routes depending on the circumstances.

Exposure of skin and respiratory tract usually causes only local symptoms (i.e., hives, conjunctivitis and rhinitis, swelling of the lip, tongue and throat) and if the allergen is inhaled into the lung, it might cause symptoms of bronchospasm. Occasionally, severe systemic reactions can occur even after just being in the operating room or the dentist's office. Some reactions result from irritation of repeated hand washing and need to be differentiated from latex hypersensitivity.

Direct mucosal and parenteral exposure pose the greatest risk of anaphylaxis. Patients who usually experience mild or manageable cutaneous (contact urticaria) or respiratory reactions are known to develop anaphylaxis after mucosal or parenteral exposure.

All latex related deaths reported to FDA have been associated with mucosal exposure to latex-containing barium catheter. Fortunately, these have been withdrawn from the market.

Risk groups

Most latex allergy occurs in persons sharing one thing in common: repeated exposure to latex. Persons at risk include health care workers, rubber industry workers and children with spina bifida and urogenital abnormalities. Anyone who is exposed to rubber or latex products repeatedly can expect to be sensitized.

The IMS Education Fund has designated this article as the Henry Albert Scientific Presentation Award for July 1995.

RK AGARWAL, MD
A AL-SHASHI, MD
The authors practice with the Allergy Institute, P.C. in West Des Moines.

Latex allergy

continued

The prevalence of latex allergy in the general population is unknown, but it is higher among atopics (those with asthma, allergic rhinitis or atopic dermatitis). Five to 10% of health care workers have evidence of IgE sensitization. The risk is higher among surgeons, dentists, operating room nurses and laboratory technicians who have to wear gloves for a longer period of time than other health care workers. The prevalence of IgE mediated sensitization in children with spina bifida varies from nine to 28%.

Diagnosis

All symptoms related to rubber product use may not be related to latex. For example, condom dermatitis may be related to spermicidal jellies, creams and foams, diaphragms and lubricants. Frequent handwashing with various soaps, detergents or disinfectant solutions can produce either an irritant or an allergic contact dermatitis.

RAST (radio-allergosorbent), "use test" and epicutaneous skin tests are used to confirm the diagnosis. For most patients with spina bifida, in vitro tests are adequately sensitive. For health care workers and others with latex allergy, RAST test has been considerably less sensitive. A negative RAST test in these subjects cannot exclude latex allergy.

There is some evidence that epicutaneous skin tests are more sensitive than the RAST. For the most part, prick skin tests are safe, but there are reports of patients developing anaphylaxis following skin testing. However, there are no reported fatalities following skin testing. For extremely sensitive patients, one can order a RAST test. If the RAST is negative, one can proceed with use test. If the use test is also negative, skin test with diluted latex allergen and test the person with increasing concentration of the latex allergen.

Prevention

Avoidance of latex products is the only way to eliminate the problem, but this is difficult as many household and medical devices contain latex products.

Health care workers with contact urticaria or contact eczema will do fine if they avoid latex gloves. The problem is harder to resolve if they experience ocular, respiratory or sys-

temic symptoms as everyone who works around them needs to switch to non-latex gloves. A partial solution to this problem is to use non-powdered gloves as their use results in less aerosolization of the latex particles.

Even if these patients become symptom-free after latex avoidance, they must be warned of the potential risk of anaphylaxis when these patients or health care workers undergo surgical procedures which expose them to latex from a variety of sources. Some patients are so sensitive that a small amount of allergen in the rubber ports for IV medications/fluids or medicine vials can induce anaphylaxis. It is important that the medical charts of all patients be labeled as latex allergic. It might be useful to give the patient a medic alert bracelet. We give all our patients a list of non-latex alternatives.

Premedication with steroids, H₁ and H₂ antagonist and ephedrine, has been tried to prevent latex-induced reactions prior to major, surgical and dental procedures, but failures have been reported. It cannot be used as an alternative to allergen avoidance, but can be considered to decrease the severity of an accidental exposure to latex.

Note: Contact the editors of Iowa Medicine for a list of latex-free alternatives for use in hospitals. ■■

Thyrotoxic periodic paralysis

● JOHN DiBAISE, MD

After a one week history of progressive muscle weakness, a 22-year-old Chinese graduate student was unable to walk. He was taking no medications, there was no family history of a neuromuscular disorder and his only other complaint was heat intolerance. The physical examination was remarkable for tachycardia, a grade II/VI systolic ejection murmur at the left lower sternal border, severe proximal muscle weakness in all extremities and diminished deep tendon reflexes in the legs.

Laboratory analysis revealed a serum potassium of 1.7 mEq/L, phosphorous of 0.8 mEq/dL, glucose of 152 mg/dL and a normal creatine phosphokinase (CPK). After administration of intravenous potassium phosphate the potassium and phosphorous levels normalized and the muscle weakness resolved. Thyroid function studies revealed a free T4 of 4.3 mcg/dL (0.5-2.1) and TSH <0.1 mIU/L (0.4-5.0). Electromyography was normal and a 24-hour radioactive iodine uptake was 82%.

While periodic paralysis was described in the late 19th century, the association between hyperthyroidism and periodic paralysis was not apparent until the early 1900s.^{1,2} Thyrotoxic periodic paralysis (TPP) occurs predominantly in Asian populations and is seen in approximately 2% of Japanese and Chinese who develop thyrotoxicosis. It is rare in other ethnic groups and occurs in only 0.2% of North Americans with thyrotoxicosis. Most cases occur in the second to fifth decade and there is a male preponderance (13:1).

Familial periodic paralysis (FPP) and TPP both involve recurrent attacks of flaccid weakness that usually begin in the legs and there may be a prodrome of muscle cramps and/or stiffness. Attacks are not usually asso-

ciated with cognitive or sensory deficits and the bulbar musculature and muscles of respiration are usually spared. Serious atrial and ventricular arrhythmias and respiratory failure have also been described.³ In Orientals hyperthyroid symptoms usually predate TPP by months to years.⁴ Recovery of muscle function occurs in reverse order of the appearance of paralysis. Moderate exercise will attenuate the severity of the attack and may hasten the recovery.⁵ Numerous triggering factors have been described, including carbohydrate load, vigorous exercise then rest, cold, trauma, infection, menses, alcohol and emotional stress. Ingestion of high carbohydrate foods and vigorous exercise followed by rest commonly precede a hypokalemic attack.⁵

The principal biochemical abnormality in TPP is hypokalemia but total body potassium stores remain normal.⁶ Serum phosphorous levels may be depressed and CPK levels are variably increased. Electromyograms and muscle biopsies reveal nonspecific changes characteristic of a myopathy.

Treatment

Spontaneous recovery within three to 36 hours is the rule. Oral potassium chloride is the treatment of choice as intravenous administration of dextrose-containing solutions may delay the correction of serum potassium and may be associated with hyperkalemia. Potassium exits muscle tissue at a rate of approximately 15 mEq/hour during the recovery phase of an acute attack.⁷ Administration of phosphate is generally not necessary as levels normalize simultaneously with potassium levels.

Management of the underlying hyperthy-

JOHN DiBAISE, MD
Dr DiBaise practices with the University of Iowa Department of Internal Medicine.

Thyrotoxic periodic paralysis

continued

roidism is the definitive treatment and until a euthyroid state is achieved, persons with TPP should avoid potential triggering events. Propranolol, potassium chloride and spironolactone have been used with limited success as prophylactic agents. After effective treatment of hyperthyroidism persons with TPP will no longer develop spontaneous or induced attacks.

Pathophysiology

TPP usually occurs in conjunction with Graves' disease but has also been reported with multinodular goiter, solitary thyroid adenoma, lymphocytic thyroiditis, iodine-induced thyrotoxicosis and thyroid hormone ingestion. No consistent genetic marker has been identified but an underlying genetic basis is suggested by family studies and the ethnic distribution.

An electrophysiologic abnormality of the skeletal muscle membrane is suspected but the precise nature of the pathophysiologic disturbance in TPP remains undefined.⁸ Grob has hypothesized that the intracellular shift of potassium into muscle results in hyperpolarization of the muscle membrane with a resultant muscle refractoriness.⁹ Insulin may also play a role in potassium shifts. Some individuals with TPP have an exaggerated insulin response to a carbohydrate load and markedly elevated insulin levels have been observed in some persons with TPP during attacks.^{10,11} Insulin may act to increase the activity of Na⁺-K⁺-ATPase causing an increase in intracellular potassium.

The exact role of thyroid hormone in TPP is uncertain. Elevated thyroid hormone levels alter plasma membrane permeability to sodium and potassium, a function linked to increased Na⁺-K⁺ pump activity.¹² Hyperthyroidism also increases tissue responsiveness to beta-adrenergic stimulation which in turn may increase Na⁺-K⁺ pump activity.¹³ In TPP, thyroid hormone may work in concert with increased insulin and beta-adrenergic activity to alter resting membrane potentials that lead to muscle paralysis.^{14,15}

References

References noted in this article are available from either the author or the editors of *Iowa Medicine*. ■

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Are you afraid of death?

There is no cure for birth and death save to enjoy the interval.

George Santayana, Philosopher, 1863-1952

We begin to die at birth; the end flows from the beginning.

Marcus Manilius, Latin poet, First century BC

I will use that regimen which, according to my ability and judgement, shall be for the welfare of the sick, and I will refrain from that which shall be baneful or injurious.

Oath of Hippocrates

Most physicians, as most people, are fearful of death. We physicians have learned to equate death with professional defeat or failure. Our lot has been to keep the dying patient alive by whatever means available, often when it is obvious such measures may be futile. Yet, there is the fear of defeat, the actual fear of death and the fear of legal reprisal when there has not been a total effort to keep the dying patient alive a bit longer.

Our Oath of Hippocrates declares that we as physicians will "use that regimen which according to our ability and judgement shall be for the welfare of the sick." This declaration does not imply that extraordinary means, though futile, be indicated. The only addition to this declaration is that we shall "refrain from using means that are baneful and injurious."

Life consists of three phases—birth, living and death. As Manilius declared centuries ago, "We begin to die at birth; and the end flows from

the beginning." As Santayana concluded, "There is no cure for birth and death save to enjoy the interval."

In a recent issue of *JAMA* (April 5, 1995, p. 1039) McCue discusses the naturalness of death. He declares that the acceptance of death directly conflicts with the medications and legalization that characterizes modern society's treatment of dying elderly patients. In years past before the technology and pharmaceutical regimens of today death was considered natural and expected. The caring physician stayed with the family during the last hours assisting in the understanding of this natural event. Our profession today has become so defensive about death that we view this last chapter of life as a medical failure and defeat.

We physicians have learned to equate death with professional defeat or failure.

McCue suggests making dying a diagnosis wherein the physician recognizes it as a chronic, incurable disease. Acceptance then negates fruitless attempts at diagnosis and cure—more consultations, drugs and technological procedures which only delay the inevitable. All this at additional cost in stress and suffering; yes, also in dollars; to all involved. However, when death is imminent it is not for physicians to terminate life by any methods of euthanasia. Life is sacred. Its beginning with birth proceeds to death by whatever pathway is set for each one. Let us view it as natural and inevitable and celebrate each life as a wonderful existence for however long it may be. **IM**



MARION ALBERTS, MD

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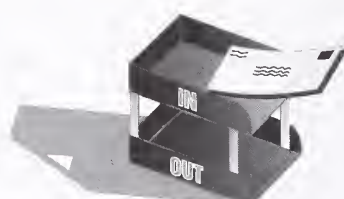
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1995 IMS HOUSE OF DELEGATES PROCEEDINGS

The 1995 annual meeting of the Iowa Medical Society House of Delegates was held April 29-30 at the Des Moines Marriott Hotel. House sessions were chaired by Donald Kahle, MD, speaker. The annual banquet was held April 29 and was emceed by James White, MD, IMS president.



HOUSE OF DELEGATES POLICY ACTIONS

Reports considered by the 1995 House of Delegates came from the Reference Committee on Medical Service and Miscellaneous Business, the Reference Committee on Legislation and the Reference Committee on Reports of Officers and Articles of Incorporation and Bylaws. Based on consideration of the reports, the IMS will take the following actions:

- Reaffirm the IMS Statement of Principles.
- Increase 1996 IMS dues by \$10.
- Maintain the current quality and format of *Iowa Medicine*, while recognizing that the Board has a fiduciary responsibility. Approved an amendment to the Bylaws striking the requirement that *Iowa Medicine* be published on a monthly basis and a resolution that the Board consider an *Iowa Medicine* subscription fee for non dues-paying members (emeritus and life members).
- Approve an amendment to the Bylaws providing for representation of Iowa medical specialty societies in the House of Delegates and the addition of a new section establishing certain eligibility requirements and an approval process.
- Approve an amendment to the Bylaws providing that the executive vice president shall be covered by the indemnification provisions.
- Continue to hold the annual meeting of the IMS House of Delegates in April.
- Make state specialty societies aware of IMS capability to provide administrative services on a fee-for-service basis.
- Establish a task force to work with other organizations on appropriate revisions of Iowa law relating to HIV/AIDS. Support physician and public education about HIV/AIDS, available preventive measures and legislative revisions to permit patient-specific information to reach the appropriate state health agencies.
- Oppose the use of the Drug Enforcement Administration (DEA) registration number for any purpose other than for verification to the dispenser that the prescriber is authorized by federal law to prescribe controlled substances. Encourage physicians to report any inappropriate requests for DEA numbers to the Iowa Board of Pharmacy Examiners and educate physicians on the reporting process.
- Continue to support the AMA's policy statement on firearm safety and regulation.
- Referred a resolution regarding pleas in criminal cases.
- IMS Task Force on Domestic Violence be continued and actively participate in legislative studies relating to domestic violence with other organizations as opportunities arise.
- Establish a Task Force on Violence Intervention and

Prevention to investigate and recommend methods to assist in keeping "unsupervised weapons" out of the hands of minors.

- Adopt a prudent layperson definition of emergency services.
- Develop a support program for physicians being sued for malpractice and include educational materials to assist local physician organizations. Work with liability insurance carriers and appropriate IMS committees to develop such a support program.
- Encourage physicians to place their assets in plans which are protected from civil liability awards including malpractice suits and that physicians be encouraged to work with pension planners to ensure pension assets are protected.
- Encourage the AMA Council on Ethical and Judicial Affairs to continue to review the ethical issues relating to appropriate care at the end of life and work with other organizations on educational strategies for end-of-life issues.
- Reaffirm its policy to strongly encourage the IFMC to provide the House of Delegates an annual report to increase communications between the two organizations.
- Adopt a 3-page IMS policy statement on CHMIS (see June 1995 issue of *Iowa Medicine* for full text).
- Support AMA efforts to eliminate entirely or develop more fairly calculated Geographic Practice Cost Indices.
- Referred a resolution regarding the start of the school day.
- Encourage students and residents to be involved in the legislative and political process.



AWARD WINNERS

At the annual banquet, Laverne Wintermeyer, MD, former state epidemiologist from Des Moines, received the 1995 IMS Merit Award. Dr. Herman Hein, Iowa City, received the Ben T. Whitaker Award of the Interstate Postgraduate Medical Association of North America. Dr. Paul Laube, surgeon from Dubuque, received the IMS Physician Community Service Award. The John H. Sanford Award was given to Jim Koch, executive secretary of the Rock Island and Scott County Medical Societies. Mary Ann Bechler, clinic administrator for the Northwest Iowa Orthopaedic and Sports Center in Sioux City received the IMS Outstanding Medical Office Administrator Award and members of the IMS Alliance were recipients of the Washington Freeman Peck Award.



APRIL 29 SESSION

Registered for the April 29 session of the House were 133 physician delegates. Minutes of the 1994 House of Delegates session were approved as summarized in the July, 1994 issue of *Iowa Medicine*.

New delegates to the House were introduced and reference committee appointments were announced.

Dr. Richard Corlin, vice speaker of the AMA House of Delegates, addressed the House and information regarding

1995 IMS HOUSE OF DELEGATES PROCEEDINGS

CONTINUED

the House agenda was reviewed.

Two checks totaling over \$18,800 were presented on behalf of the AMA-Education and Research Foundation to Dr. Robert Kelch, dean, University of Iowa College of Medicine. The funds, raised primarily through the efforts of the IMS Alliance, are to be utilized by the U of I College of Medicine's excellence fund and assistance fund.

REPORTS TO THE HOUSE

Reports contained in the 1995 House of Delegates handbook were approved.

Supplemental reports from the Board of Trustees, Judicial Council and two committees were referred to reference committees. The physicians' memorial list was presented by Dr. Kathryn Ophiem, chairman of the IMS Judicial Council, with delegates observing a moment of silence in honor of deceased physicians.

Informational reports were submitted by the IMS Education Fund, IMS Services and MMIC. Dr. James White presented his address as outgoing IMS president, emphasizing the need to minimize the effect of governmental regulations on the practice of medicine.

IMS OFFICERS FOR 1995-96

The report of the Nominating Committee was read. The following officers were elected:

President-elect	William McMillan, MD, Ottumwa
Vice president	Sterling Laaveg, MD, Mason City
Trustee (3-year term)	Siroos Shirazi, MD, Iowa City
Speaker, House of Delegates	Donald Kahle, MD, Dubuque
Vice speaker	Tom Throckmorton, MD, Spencer
AMA delegates (2-year term)	Clarkson Kelly, Jr, MD, Charles City
	Daniel Youngblade, MD, Sioux City
AMA alternate delegates (2-year term)	Bernard Fallon, MD, Iowa City
	Bryan Pechous, MD, Dubuque

Four District Councilors were also chosen. They are: Robert Kent, MD, Burlington (District I); John Justin, MD, Mason City (District VI); Jay Heitzman, MD, Ottumwa (District IX); and Linda Iler, MD, Lake City (District XIII).

Sixteen resolutions submitted by councilor districts were introduced and referred to reference committees. Actions taken on the resolutions are reported subsequently.

The speaker presented information on the Reference Committee hearings and the concluding session of the IMS House of Delegates.

LIFE MEMBERS

The following physicians were elected to life membership in the Iowa Medical Society. (Life members are physicians who have practiced medicine for 50 years and have been mem-

bers of the IMS for 15 consecutive years):

Robert Allen, MD, Burlington; William Baird, MD, Ames; Elmer Bean, MD, Council Bluffs; James Coffey, MD, Emmetsburg; Eugene Coffman, MD, Bellevue; Russell Conkling, MD, Cedar Rapids; Dean Cooper, MD, Fort Dodge; Thomas Coriden, MD, Sioux City; Richard Corton, MD, Waterloo; Robert Donlin, MD, Harlan; Harley Feldick, MD, Iowa City; Frederick Fuerste, MD, Dubuque; Louis Greco, MD, Boone; Charles Gutenkauf, MD, Des Moines; John Huey, MD, Cedar Rapids; Robert Jongewaard, MD, Wesley; James Kennedy, MD, Coralville; Walter Kopsa, MD, Tipton; Otto Kruse, MD, Tipton; Rufus Kruse, MD, Marshalltown; Jean Le Poidevin, MD, Waterloo; Edward Mason, MD, Iowa City; Emmett Mathiasen, MD, Council Bluffs; Roger Mattice, MD, Emmetsburg; Theodore Mazur, MD, Burlington; Richard Miller, MD, Waterloo; Robert Morrison, MD, Waterloo; Jack Moyers, MD, Iowa City; Gerald Nemmers, MD, Washington; Don Newland, MD, Des Moines; Loran Parker, MD, Des Moines; Gordon Rahn, MD, Mt. Vernon; John Singer, MD, Iowa City; Glenn Skallerup, MD, Red Oak; William Spencer, MD, Osage; Warren Swayze, MD, Muscatine; Joel Teigland, MD, Des Moines; John Thomsen, MD, Armstrong; Russell Van Wetzinga, MD, Bettendorf; Donald Wagner, MD, Sioux City; Janet Wilcox, MD, Iowa City; and Grey Woodman, MD, Clinton.

Emeritus IMS membership was accorded to 55 physicians.

APRIL 30 SESSION

Registered for the April 30 session of the House were 103 delegates. Minutes of the April 29 session were read and approved.

Mrs. Barbara Bell, past president of the Iowa Medical Society Alliance, addressed the delegates regarding Alliance projects during the past year. Mrs. Sandra Mitchell, president-elect of the American Medical Association Alliance, also addressed the House.

The House of Delegates acted on reports from three reference committees and the speaker acknowledged the efforts of the committees. The House was adjourned and Joseph Hall, MD of Des Moines was installed as president for the coming year.

Organizational meetings of the IMS Board of Trustees and Judicial Council occurred following Dr. Hall's installation.

What's in a name?

My regular readers might recall that I occasionally voice my interest in words and meanings. I suppose I've always had some degree of interest or curiosity about them, but as I've grown older I feel ever more urgently the power for good or ill of those abstract symbols we call words. The Hebrew Bible (Genesis, Chap. 11:1-9) tells the wonderful story of the tower of Babel, which as a child I always found interesting and picturesque. Even in biblical times there was recognition of the enormous (and therefore theologically threatening) power if everyone "spoke the same language"; thus arose the "justification" for multiple languages and the associated dispersion of groups of people.

Often we hear people dismiss disagreements about words as "just semantics". Just? Another uncritical maneuver is to ask the question, "What's in a name?" to imply that names make no difference. One should always remember the source and purpose of that question. It's a wonderfully persuasive, seductive line that Shakespeare assigned to

Romeo's use in convincing Juliet that his family name, Montague, hated by her Capulet family, need not impede their romance. Unfortunately for them and so many others, hatred often runs thicker than love. Or consider the great number of requests tallied each year by the American Library Association to remove *Huckleberry Finn* from school or public libraries because Mark Twain names his major character

"Nigger Jim" and today the adjective has grown painful and pejorative. If your doctor says, "We finally have a diagnosis: cancer of the pancreas," are you likely to respond, "Oh well, one diagnosis is as good or bad as another"? A patient whom I met recently while visiting the Gillis W. Long Hansen's Disease Center at Carville, Louisiana (formerly called our national leprosarium) described the anguish and dreadful consequences in his own life and that of his family caused by the use of the words "leper" and "leprosy". A worldwide effort is underway to change the terminology to Hansen's Disease.

These reflections about words and meanings have been prompted by a card that just came from the Iowa Medical Society, cautioning the

A worldwide effort is underway to change the terminology to Hansen's Disease.

reader, if "about to sign a managed care contract", to consider a list of contract pitfalls. Crucial phrases include "hold harmless clause", "due process rights", "non-competing covenants", "evergreen clause". The final question, "How and how much will you be paid?" has nice familiar one-syllable words that convey an idea I can grasp easily; those other phrases are pitfalls indeed. As the message suggests, an appropriate translator (often called an attorney) is indeed someone "you may wish to consult". Words may convey delight—even ecstasy—but never let yourself fall prey to the childhood shibboleth which claims that while sticks and stones may break my bones, words will never hurt me. **IM**



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Chief Surgical Service/Residency Program Director—The Department of Veterans Affairs Medical Center, Des Moines, Iowa, invites applications for Residency Program Director and Chief, Surgical Service. The VAMC is a 153-bed acute medical surgical hospital with a large multispecialty outpatient program. The General Surgical Residency Program recently was fully accredited by the ACGME. Applicants should be academically oriented with administrative abilities and experience in post-graduate medical education. In addition, they should be board certified in general surgery. Regular hours, liberal fringe benefits and a competitive salary. Des Moines combines the advantages of Midwestern small town family living with the cultural amenities of an urban center. This city is particularly noted for the excellence of its public and parochial school systems. Submit CV to the Chief of Staff, VAMC, 3600 30th Street, Des Moines, Iowa 50310, 515/271-5853. EOE.

Ramsey Clinic—A 250-physician multi-specialty group based in downtown St. Paul operates a small network of clinics in Maplewood and western Wisconsin. We currently have 2 openings for board certified/board eligible family physicians at Ramsey Clinic-Maplewood and the Family Medical Clinic in Amery, Wisconsin. Both clinics boast personable physician colleagues and support staff, thriving practices, private-like practice settings and access to specialty consultations and administrative support. Excellent call schedule, a first year salary guarantee and comprehensive benefits package. Send CV to Aynsley Smith, Ramsey Clinic, 640 Jackson Street, St. Paul, Minnesota 55101 or call 612/221-4230.

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Springfield, Missouri—Bass Pro Shop and 40 miles to Branson. BE/BC FPs. OB optional, salaried position and production bonus, call 1:7, teaching hospital, university community. Contact Vivian M. Luce, Cejka & Co., 1/800-765-3055 or fax CV for immediate attention to 314/726-3009 (IMs welcome).

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Stoughton, Wisconsin—Dean Medical Center, a 350-physician multispecialty group is actively recruiting a BE/BC family physician for our Stoughton Clinic, which is located approximately 20 miles south of Madison (population 190,000). Currently there are 3 internists, 4 family practice physicians, one pediatrician and one general surgeon at this clinic. Call would be shared equally among the family physicians. The Stoughton Hospital is a 50-bed facility adjoining the new medical office building. Stoughton has a population of approximately 9,000 and growing with excellent schools and neighborhoods. This is an excellent position which enables you to live in a safe community with the cultural and professional resources of a larger city just minutes away. A two-year guaranteed salary plus incentive and benefits is being offered for this position. Contact Scott Lindblom, Dean Medical Center, 1808 West Beltline Highway, Madison, Wisconsin; 1-800/279-9966; 608/250-1550 (work); 608/833-7985 (home); or fax 608/250-1441.

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(Continued next page)

Advertising Rates and Data

Regular classified advertising sells for \$2.00 per line with a \$30 minimum per insertion. For members of the Iowa Medical Society the rate is \$20 per insertion. Display classified advertising sells for \$25 per column inch, per month. Sizes range from 1 column by 2 inches to 1 column by 6 inches. A variety of type sizes, borders, reverses or screens can be included in the ad. Blind box numbers are available upon request at no additional charge. Copy deadline is the 1st of the month preceding publication. Send or fax copy to Iowa Medicine, 1001 Grand Avenue, West Des Moines, Iowa 50265-3599, fax 515/223-8420.

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Principles of Medicare reform

Reform of Medicare will be a priority during the coming year. At the AMA Annual Meeting, Speaker of the House Newt Gingrich made a satellite presentation. The key issues will be making multiple choices available such as medical savings accounts, voucher system, a fee-for-service and continuation of the current system. I believe this will be our best opportunity to affect real changes in Medicare. To balance the federal budget, the debate must be shifted from provider cuts to Medicare reform. Physicians account for 23% of the Medicare dollars and have absorbed 32% of Medicare cuts over the last decade. This poses a real threat to access.

The AMA believes reform must incorporate five basic principles:

1. Beneficiary cost consciousness must be encouraged. It may be necessary to ask those who have the ability to pay higher premiums to do so. "Medigap" insurance insulates many beneficiaries from the cost of medical services.

2. Price competition among physicians and providers must be facilitated to increase economic efficiency. Mechanisms that allow beneficiaries to participate in their health care decisions on the basis of service, quality and price should be established.

3. Intergenerational inequity and financing must be reduced. Four workers support each beneficiary; however, this falls to two workers by the middle of the next century. The working

population cannot be expected to pay higher taxes.

4. Dependence of future generations on Medicare must be reduced. Incentives should be created for more people to become financially independent of Medicare during retirement.

5. Regulatory and administrative complexity must be curtailed.

The most rapidly growing components of Medicare Part B are payments to outpatient hospital facilities, independent laboratories and home health services. The Medicare population is growing faster than the general population.

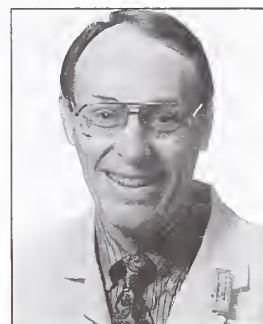
Since 1967, the number of enrollees has increased from 19.5 to 35.2 million. By 2030 it's projected approximately 20% of the U.S. population will be over 65.

Technological progress in medicine has been a significant factor increasing the cost of Medicare.

The increased rate of use with more expensive consumption of expanded benefits increased the amount paid per enrollee by 1,340% when compared to the inception of the program in 1966.

It is no wonder that benefit payments of \$4.7 billion in 1967 have increased to \$159 billion in 1994.

The dialogue is just beginning. This time it's possible that ideas physicians have espoused since 1986 may be heard. **IM**



JOSEPH HALL, MD

**The debate
must be
shifted from
provider cuts
to Medicare
financing reform.**



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Organized medicine: it's for students, too

Having recently completed a six-week summer internship at the Iowa Medical Society, I have a message to share with other students on the importance of organized medicine. As you go through medical school, you will probably hear little from the medical school faculty about organized medicine and its importance to your future as a doctor. This is an unfortunate consequence of the sheer amount of material medical students are expected to absorb and the fact that there is not time to include more information in the curriculum.

In the real world, medicine is coming under the increasing control of governmental agencies and private insurance companies. It is vital that doctors understand the issues that fall outside the realm of clinical medicine and into that of "organized medicine".

What is organized medicine? Put simply, it is the affiliation of physicians into professional organizations that act as advocates for and provide assistance to doctors on a variety of topics from medical liability reform to Medicare reimbursements. The American Medi-

cal Association (AMA) is the largest and most prominent professional organization for doctors. The AMA is part of what is called the "Federation of Medicine" that includes state medical societies and scores of county and local societies. The AMA and the IMS offer and encourage membership in the Medical Student Section (MSS) to medical students, allopathic and osteopathic alike.

When you will soon be tearing your hair out over the Krebs cycle in biochemistry, why should you join the Medical Student Section of the AMA or IMS? It is understandable that medical students would want to not be bothered by economic and political matters when they are trying to learn medicine, but no matter how altruistic your motives for becoming a doctor, medicine and the control of patient care is increasingly being taken from physicians and given to government and private insurance companies. Physicians are being paid less for the work they do, and, more importantly, must justify their treatment decisions to non-medical professionals. When doctors are forced to consider the bottom line over patient well-being, the doctor-patient relation-

ship is compromised.

Becoming involved in organized medicine through membership in the Medical Student Section of the AMA and the IMS is one additional way to insure the highest quality of health care for our patients. The membership fee is less than the cost of many medical text-

The membership fee is less than the cost of many medical textbooks.

books and there are many benefits.

The competition to get into medical school is as tough as it has ever been and your presence in the first year class is a testament of your commitment to academic excellence. Your participation in organized medicine will help assure that the commitment you have already made for a rewarding career helping patients will be realized. **IM**



ERIC STONE, M2

Eric Stone is a second year medical student at the U of I College of Medicine. He is a native of Ames. For information on joining the Medical Student Section of the IMS, call Sandy Nelson at 800/747-3070.

IMS Update

AT A GLANCE

Regina Benjamin, MD, MBA is the first physician elected to the American Medical Association Board of Trustees "young physician member" post. Dr. Benjamin, the only practicing physician in Bayou LaBatre, Alabama, was named ABC News "Person of the Week"; Time Magazine called her one of America's 50 future leaders under the age of 40.

Women's Health '95, a one-day conference, will be held Friday, September 15 at Drake University's Olmstead Center. Keynote speakers will address a number of women's health issues. The conference is cosponsored by the University of Iowa; physicians attending will earn AMA Category 1 credits. For more information, call Drake University, 515/288-4543 or fax 515/288-4745.

IMS to participate in national conference

The Iowa Medical Society has been asked to participate in a national conference on violence prevention. Sponsored by the Centers for Disease Control, "Bridging Science and Program" will be held October 22-25 at the Des Moines Convention Center.

The conference will be organized around four tracks: family/domestic violence, youth violence, suicide and workplace violence. The IMS has been asked to do a presentation on domestic violence. Staff at the University of Iowa Injury Prevention and Research Center will work with members of the IMS Task Force on Domestic Violence regarding the Society's portion of the program.

The conference is funded by a grant obtained for Iowa by Senator Tom Harkin. It will be open to members of any profession interested in violence issues. Conference organizers say Vice President Al Gore and

possibly Mrs. Clinton will attend some portion of the program.

Watch future issues of *Iowa Medicine* for further details about this conference.

AMA condemns medical patenting

The patenting of medical procedures may increase the cost of treatment and thus limit patient access to the procedures, says the AMA's Council on Ethical and Judicial Affairs.

"Since the time of Hippocrates, physicians have relied on the open exchange of information without expectation of financial reward for advancing medical science," said John Glasson, MD, chair of CEJA. **IM**

SPECIALTY SOCIETY UPDATE

We welcome the Iowa Association of Pathologists, which has joined 10 other specialty societies receiving staff support from IMS Services. The IAP is one of an increasing number of specialty societies finding their member officers have insufficient time to fulfill the responsibilities of their association. If you belong to an association interested in discussing staff services, contact Dana Petrowsky, manager, specialty services, 800/728-5398.

The IMGMA Fall Meeting will be September 13-15 at Lake Okoboji. The theme is "Winning through Teamwork". There will be a panel discussion of new directions in physician-hospital partnerships led by Steve Brenton, president of the Iowa Hospital Association.

The Iowa Psychiatric Society and the Mental Health Advocacy Coalition are planning a special event to take place during Mental Illness Awareness Week October 5. The theme — "The Benefit of Benefits" — involves parity of mental health benefits under insurance coverage.

The Iowa Vascular Surgery Society held its Spring Meeting July 14-15 in Davenport.

In a recent *Iowa Medicine*, Dr. Jeffrey Watters was incorrectly listed as newly-elected president of the American Academy of Otolaryngology. Dr. Watters is president of the American College of Radiology, Iowa Chapter.

FOCUS ON IMS ALLIANCE

On June 18-21, I was privileged to attend the AMA Alliance Annual Meeting in Chicago. Listening to Dr. Robert McAfee (immediate past president of the AMA) was inspiring, but the statistics on family violence are truly astounding. During the last two weeks, at least one patient in your spouse's office was a victim of family violence. Who was it?

Family violence is categorized under four headings: child physical abuse, child sexual abuse, spouse abuse and elder abuse. We in the IMSA are committed to decreasing this explosion of violence in our communities. Won't you and your spouse join us? The IMSA is involved in educational programs to help us change this behavior and we would welcome your help. We all lead busy lives, but if this epidemic is to be brought under control, we have to start at home. Please join me, the IMS Alliance and the Iowa Medical Society in helping educate Iowans about family violence.

For more information on joining the Alliance, call me or Sandy Nichols at 800/747-3070.

Contributed by Linda Miller, president, IMSA

Futures

Medicare under a microscope at AMA

The AMA unveiled its "Medi-Choice" plan to reform Medicare at a press conference during the AMA 1995 House of Delegates in Chicago. The AMA's plan would change the system from one which guarantees set benefits to one that guarantees contributions and lets beneficiaries decide how to spend them.

The AMA says its plan — which will feature a number of different options for Medicare recipients — will save the federal government about \$162 billion over seven years.

The AMA's reform ideas are not falling on deaf ears. During a videocast speech to physicians attending the AMA meeting, Speaker Newt Gingrich displayed a yellow book containing the AMA's working draft. Gingrich's speech featured an anti-government, pro-free enterprise theme.

Lonnie Bristow, MD, AMA president, said Congress will never get a grip on costs until incentives are changed. The AMA believes the program needs a complete overhaul, focusing on five points: individual responsibility, correcting the transfer of funds across generations and among the elderly, cutting paperwork, using competition to control costs and reducing unnecessary care.

The best existing program after which the new Medicare program could be modeled is the Federal Employees Health Benefit Program. People who buy a lesser package of benefits are at risk to pay the remainder if they need care which is not covered.

The plan would introduce competition among doctors by eliminating Medicare's dictated prices. Doctors would post their prices and patients could choose practitioners.

The AMA believes the plan will remove the need for Medigap policies which increase utilization.

The AMA also favors raising the eligibility age for Medicare and income testing to remove the subsidy for wealthy older Americans.

Ganske speaks out on Medicare

According to a recent article in the *Des Moines Register*, Rep. Greg Ganske believes medical savings accounts may be the best way to check the unsustainable growth in Medicare. Rep. Ganske, a Des Moines reconstructive surgeon, distributed a position paper outlining his views to members of Congress.

Ganske strongly opposes greater use of managed care for Medicare beneficiaries, an idea which some Republicans support. He believes the idea wouldn't save money and could jeopardize the quality of care.

"Unless we make major structural changes in Medicare, we are merely rearranging deck chairs on the Titanic," Ganske commented in his paper.

Ganske is a member of a House committee with jurisdiction over a portion of Medicare.

Headed for a clash?

Angry physicians and giant managed health care companies are headed for a clash, experts said during a recent debate sponsored by the Institute of Medicine in Chicago.

Physicians say the results of the conflict may be a health care system more personal than today's increasingly cold business, but more efficient than yesterday's cost-blind private practice.

"Managed care is not a destination, but a journey," commented James Todd, MD, the AMA's executive vice president.

The former editor of the *New England Journal of Medicine* said there is a "growing discontent among physicians. During my 50-year career in medicine, I've never seen a time when doctors are more distressed and concerned about the future of their profession."

The major factor is the rise of HMOs and

continued

AT A GLANCE

Blue Cross Blue Shield has announced that, beginning July 1, Milliman & Robertson's Health Care Management Guidelines will be incorporated into utilization management review criteria. These practice parameters are already being used by other health care organizations. A review of the Milliman & Robertson practice parameters will be on the agenda at a fall meeting of the IMS Committee on Medical Service. For more information, call Barb Heck at the IMS, 800/747-3070 or 515/223-1401, ext. 627.

As of press time, congressional hearings on the future of Medicare and Medicaid were underway once again, and the AMA is continuing to pursue all appropriate opportunities to present transformation recommendations.

Futures

continued

other companies that have attempted to apply the bottom-line of business to the art of medicine, said debaters in Chicago.

Regulatory summit in Newton

Easing the burden of health care regulation will be the main item on the agenda at an August 29 "regulatory summit" in Newton. The IMS participated in a steering committee which planned the summit.

The purpose of the summit is to bring together "regulators" and "regulatees" to discuss coordinating and streamlining health care regulation in the environment of reform.

Bruce Vladek, director of the Health Care Financing Administration, will be a guest speaker.

Watch for a report on the summit in the September *Iowa Medicine*.

CHMIS Governing Board update

Patient-specific data and transaction charges were considered at a recent meeting of the CHMIS Governing Board.

The Governing Board, which includes Beth Bruening, MD and Dale Andringa, MD, discussed the difference between patient data and patient information. It was pointed out that the original CHMIS steering committee did not envision release of patient-specific data. From the beginning of CHMIS development, the IMS has argued against release of any patient-specific data.

The Governing Board voted to accept the concept that patient-specific data will not be released. Exact definitions of "patient-specific" and "patient identifiable" will be presented at a later meeting.

The Governing Board also discussed the issue of financing the CHMIS system through a per-transaction surcharge. The party who benefits the most from electronic processing will pay the per-transaction surcharge. One interpretation is that payers benefit from claim submission, preauthorization and remittance advice; providers benefit from insurance eligibility verification and claim status.

Other updates from the CHMIS Governing Board meeting include:

- The Quality Advisory Committee has expressed concern about the quality of data entered into the CHMIS if the issue of V-codes is not addressed. The problem is

caused by the fact there are inconsistencies in how insurance companies pay V-codes.

- Several subcommittees to the Data Advisory Committee have been appointed to deal with outpatient pharmacy data elements to be included from insurance claims, standard reports to be generated by the CHMIS data repository and the minimum data set and process for collecting patient satisfaction and health status surveys.


- The Board discussed establishing a "copy-right" to ensure that purchasers of data cannot resell the data base. However, it was emphasized that CHMIS has no control over conclusions that may be drawn from the data. Outside entities cannot say CHMIS endorses any report prepared externally.

- The concept of the data repository storing information in "journals" was discussed. It was suggested that data in the repository be matched (insurance claim data with payments), overriding original information with resubmitted claims so there is no duplication.

- Networks will be governed by fines; there will be rules regarding how they can use data they collect. A network can build its own data repository if the network obtains proper authorizations and contracts with providers they serve. Iowa statutes will protect disclosure of patient-specific data.

- The Request For Proposal (RFP) for the data repository is expected to be finalized by the end of August. The Network Certification Task Force presented their revised criteria to the full advisory committee in late June. There are no certified networks at this time; it will probably be early in 1996 before a network is certified.

- The CHMIS Governing Board will not discuss details of the cost of funding and operating the CHMIS until after RFPs are received. Besides per-transaction charges, the Governing Board also discussed membership or license fees as a possible source of funds.

- Dr. Andringa brought up possible problems providers residing in border communities may have in meeting CHMIS requirements. These providers see many Iowans who work out-of-state and have insurance with a company not licensed in Iowa. However, other Governing Board members said this should not be a problem since providers will use their networks to file electronically and the networks may go to paper claims to submit to any insurance company not required to participate in CHMIS. 

The purpose of the summit is to discuss streamlining health care regulation in the environment of health care reform.

IMS staying involved in the CHMIS process

July 1, 1996—the implementation date for the Community Health Management Information System (CHMIS)—is less than one year away and Iowa physicians must be aware of what they must do to be prepared. Included with this *Iowa Medicine* is an educational insert for physicians. This insert was produced by the Communications and Education Advisory Committee of the CHMIS Governing Board.

The CHMIS Governing Board has stated quite clearly they fully expect CHMIS to be implemented on schedule. Only physicians (MDs and DOs), hospitals and outpatient pharmacies will submit data to CHMIS on July 1, 1996. Other providers such as dentists, chiropractors, optometrists, etc., will participate during Phase I after a one-year notice of their expected implementation date.

The IMS has been instrumental in shaping the development of CHMIS. We argued successfully that electronic insurance eligibility verification must be available July 1, 1996. This system should verify the patient's insurance and effective dates, co-pay amounts and the procedures which require pre-authorization. Up-to-date status on how much of a patient's deductible has been met will probably be added later in Phase I.

It has also been decided that CHMIS will not release information identifying a patient by name. Data to conduct longitudinal research studies which track an individual's encounters through the health system will be available, but

never in such a way that would allow a researcher to identify with certainty an individual's name, address, social security number, etc. IMS physicians serving on CHMIS advisory committees have spoken very effectively on protecting patient confidentiality.

CHMIS will not release provider-specific reports. CHMIS reports will discuss aggregate data, i.e., most common diagnoses, total health expenditures, etc. However, this will not preclude any other interested organization from buying the CHMIS data base, analyzing the data for their specific purposes, issuing reports and drawing conclusions from their analysis. This may include provider-specific data.

Finally, IMS physicians have actively pursued an equitable sharing among all stakehold-

**They fully
expect
CHMIS
to be
implemented
on schedule.**

ers of costs necessary to fund CHMIS. From the outset, the IMS has argued that the cost of CHMIS should not increase the expense to operate a practice.

To finance CHMIS, a surcharge will be added to all transactions, in addition to what networks may charge physicians and payers. The

Governing Board has directed that the party who benefits most from electronic CHMIS transactions will pay the surcharge.

CHMIS will be here before we know it. Offices already computerized and sending electronic insurance claims are well-positioned to meet CHMIS requirements. Offices which are not computerized will have several options available to comply with CHMIS. **IM**



TERRENCE BRIGGS, MD

Dr. Briggs, a Marshalltown obstetrician, is chair of the Iowa Medical Society's CHMIS Committee. Ed Whitver and Barb Heck, IMS staff, are available to answer questions or help you develop a strategy as July 1, 1996 approaches.

Legislative Affairs

AT A GLANCE

According to a recent article in the Des Moines Business Record, freshman congressman Greg Ganske, a Des Moines surgeon and one of 73 incoming freshmen, is gaining a reputation for being "thoughtful and issue-oriented; not a grandstander." The National Journal, a Washington political magazine, compliments Rep. Ganske for "showing spunk" by taking on the GOP braintrust and for gaining a seat on the powerful Commerce Committee.

The fight over how and when to balance the budget is "getting serious" and could go into the fall, says the Kiplinger Newsletter. The House and Senate will soon approve a compromise which trims spending growth by \$1 trillion over the next seven years, the newsletter predicts. Congress may put a dollar limit on Medicare for future years and fill in the blanks later.

Votes on key issues by Iowa lawmakers

The June *Iowa Medicine* carried a review of 1995 legislative issues of interest to the IMS. Health-related issues were not at the top of legislative leaders' agendas in 1995; consequently there were fewer roll call votes of interest to the IMS.

On many controversial issues the action took place in committee with no votes by either the full Senate or House of Representatives. For example, there were no roll call votes on the IMS bill to define surgery or on the any willing provider issue. We may see more action on some issues in 1996.

Following are the votes on several key issues. (Votes for IMS position in bold.)

● *HF 394 — IMS bill reducing statute of limitations for minors in medical malpractice cases. (No vote in Senate on this issue.)*

HOUSE — Ayes: Arnold, Baker, Bell, Blodgett, Boddicker, Boggess, Bradley, Branstad, Brauns, Brunkhorst, Carroll, Churchill, Coon, Corbett, Cornack, Cornelius, Daggett, Disney, Drake, Drees, Eddie, Ertl, Garman, Gipp, Greig, Greiner, Gries, Grubbs, Grundberg, Hahn, Halvorson, Hammitt, Hanson, Harrison, Heaton, Houser, Huseman, Jacobs, Klemme, Kremer, Lamberti, Larson, Lord, Main, Martin, Mascher, May, Mertz, Metcalf, Meyer, Millage, Mundie, Nelson B., Nutt, O'Brien, Rants, Renken, Running, Salton, Schulte, Siegrist, Sukup, Teig, Tyrrell, Van Fossen, Vande Hoef, Veenstra, Weidman, Weigel, Welter, Van Maanen.

HOUSE — Nays: Bernau, Burnett, Cataldo, Cohoon, Connors, Doderer, Harper, Holveck, Hurley, Jochem, Koenigs, Kreiman, Larkin, McCoy, Moreland, Murphy, Myers, Nelson L., Ollie, Schrader, Shoultz, Warnstadt, Wise, Witt. Not voting: Brammer, Brand, Dinkla, Fallon, Thomson.

● *SF 258, requiring setting of fees for copies of medical records provided to attorneys.*

SENATE — Ayes: Bisignano, Black, Boswell, Connolly, Dearden, Deluhery, Dvorsky, Fink, Flynn, Fraise, Gettings, Giannetto, Gronstal, Halvorson, Hammond, Hansen, Horn, Husak, Judge, Kibbie, Murphy, Neuhauser,

Palmer, Priebe, Sorensen, Szymoniak, Vilsack.

Nays: Banks, Bartz, Bennett, Boettger, Borlaug, Douglas, Drake, Freeman, Hedge, Iverson, Jensen, Kramer, Lind, Lundby, Maddox, McKean, McLaren, Redfern, Rensink, Rife, Rittmer, Tinsman, Zieman.
HOUSE — No vote in 1995.

● *SF 117, Uniform Anatomical Gift Act.*

SENATE — Ayes: All except those not voting. Not voting: Hansen, Judge, Maddox.

HOUSE — Ayes: All except those not voting. Not voting: Brammer, Ertl, Hammitt, Hurley.

● *SF 118, statewide trauma system.*

SENATE (first version) — Ayes: Bartz, Bisignano, Black, Boettger, Boswell, Connolly, Dearden, Deluhery, Drake, Dvorsky, Fink, Flynn, Freeman, Gettings, Giannetto, Gronstal, Hammond, Hansen, Horn, Husak, Judge, Kibbie, Kramer, Lundby, Maddox, Murphy, Neuhauser, Palmer, Priebe, Redfern, Rife, Rittmer, Sorensen, Szymoniak, Tinsman, Vilsack, Zieman.
Nays: Banks, Bennett, Borlaug, Douglas, Halvorson, Hedge, Jensen, Lind, McKean, McLaren, Rensink.
SENATE (final version as amended by House) — Ayes: All senators.

HOUSE — Ayes: All except as follows. Nay: Meyer.
Not voting: Brammer, Ertl, Rants.

Drug therapy management by pharmacists

The Board of Pharmacy Examiners has

THANK YOUR LEGISLATORS!

Please thank legislators who voted with us on these issues. Whether or not your legislators supported the IMS position, take the opportunity this summer and fall to get to know them. Few legislators have a background in health care; most will appreciate you taking the time to help them learn more about the issues. Call Paul Bishop of the Iowa Medical Society staff, 515/223-1401 or 800/747-3070, ext. 621 for help in working with legislators.

proposed rules to allow pharmacists to provide drug therapy management under protocol or guidelines from a prescribing practitioner (physician, physician assistant, nurse practitioner, dentist, podiatrist).

According to the proposal, drug therapy management would include the authority to:

- "Initiate, modify and manage drug therapy";
- "Collect and review patient drug histories";
- "Measure and review routine patient vital signs including pulse, temperature, blood pressure, and respiration"; and
- "Order and evaluate the results of laboratory tests relating to drug therapy including blood chemistries and cell counts, drug levels in blood, urine, tissue, or other body fluids, and culture and sensitivity tests when performed in accordance with guidelines or protocols applicable to the practice setting."

IMS has submitted comments opposing these rules. The activities described are the practice of medicine. Physicians do not have the legal authority to delegate the practice of medicine to pharmacists, whether or not it is done according to protocol or guidelines.

Pharmacists have a great deal of training relating to use of drugs and their effects; however, they lack training in direct patient care including the diagnosis and treatment of illness, and they do not have access to patient medical records.

While there may be ways for physicians and pharmacists to work more closely together in many settings, the rules as proposed provide no quality assurance mechanisms or other patient safeguards.

For copies of the proposed rules and IMS comments, contact Becky Roorda at the IMS.

Prior authorization for Medicaid drugs

The IMS was successful in efforts to remove Ritalin from the list of drugs for which treatment failure with the generic would be required before it could be prescribed for a Medicaid patient. The Department of Human Services (DHS) agreed to remove Ritalin from the list because of studies showing the generic is not as effective as the name brand.

Watch your Medicaid informational mailings for the list of generic drugs to be used for Medicaid patients beginning September 1, 1995. These drugs have been classified by the FDA as "A-rated generic bioequivalents" and

should be used in place of the name brand.

Treatment failure with the generic version must be documented before the name brand will be authorized by Medicaid. Prior authorization will not be required for the generic.

IMS recommendations on Medicaid program

The IMS has made several recommendations to the state Council on Human Services as it puts together the Medicaid budget and legislative package for the 1996 legislative session. Recommendations include improving low Medicaid reimbursement rates for physicians.

While rate increases for obstetrical and pediatric care over the last few years have helped maintain access to these services, other services should be reviewed for possible increases.

The IMS requested that DIIS consider the burden placed on practicing physicians when cost saving measures such as prior authorization for prescription drugs are recommended.

While the IMS supports reasonable cost-containment, measures which increase the administrative burdens may have the undesirable effect of decreasing access to physician services, particularly when combined with low reimbursement rates.

The IMS also noted that the implementation of managed mental health care within Medicaid has been problematic. While expressing appreciation for the steps DHS has taken to resolve problems, the IMS encouraged the Council and DIIS to continue to monitor the program and to work closely with physicians on this and other managed care programs.

Statute of limitations

With the able assistance of University of Iowa medical student Eric Stone, the IMS is compiling comprehensive information on statutes of limitations for minors in medical malpractice cases in other states.

The project includes information on statutes and relevant court decisions and will be the most up-to-date information available in the country. This information will be used to support IMS efforts to gain legislative passage of a reduced statute of limitations for minors. **IM**

The IMS is compiling information on statutes of limitations for minors in medical malpractice cases in other states.

Medical Economics

AT A GLANCE

The media has focused attention recently on the policies being set by insurers for obstetrical patients. Though many groups — including the AMA — are questioning the policies, more and more insurers are limiting length of hospital stay to one day for uncomplicated deliveries. Recently, the Iowa Farm Bureau Board of Directors approved the one-day stay for its members. C-section deliveries get a hospital stay of three days.

A Minnesota judge has refused to dismiss a lawsuit filed by the Minnesota attorney general and Blue Cross/Blue Shield of Minnesota against the tobacco industry. The suit is aimed at recouping health care costs of smokers. The tobacco industry had argued that the plaintiffs had no grounds to bring the claims.

New rules on medical records

According to a recent *Iowa Administrative Bulletin*, the Industrial Services Division has filed emergency rules regarding charges for information from medical records in Workers' Comp cases. The rules were effective May 17 and apply to Workers' Comp cases only. IMS has provided numerous comments on this subject during the past two years.

Rules require medical providers to give an employer or insurance carrier copies of the initial and final assessments without cost when needed to determine liability for a claim or payment of a provider's bill. Charges are set for duplication of additional records or reports that may be requested.

The rules provide that the fee structure will be reviewed every year. For the first year, the rules allow actual expenses or a base charge ranging from \$20 to \$90 per record plus 10 cents to \$1 per page, depending on the record's length.

For more information, call IMS staff members Becky Roorda or Barb Heck at 51/223-1401 or 800/747-3070.

Medicaid Point of Sale

Beginning October 1, Medicaid will offer physicians the option of submitting claims electronically through their Point of Sale (POS) system.

This means that while the patient is still in the office, the physician can electronically transmit the patient name, ID number, procedure performed, diagnosis codes, charges and date of service directly to Medicaid. Medicaid will instantaneously transmit the patient's Medicaid eligibility status back to the physician. The claim will be processed that weekend with checks written and mailed to physicians on Monday.

The advantages for physicians are confirmation of Medicaid eligibility and payment at the time of service and faster payment.

Participation is optional. The physician's software vendor will need to make special arrangements in order to link directly with Medicaid (through Unisys). There may be a charge for the POS system from the physician's software vendor.

For more information, call Ed Whitver of the IMS staff, 800/747-3070.

Medicaid ID cards

The Department of Human Services has established a work group to study a new design for the format of the Medicaid ID card and to determine whether the monthly issuance of the cards should continue.

The DHS hopes to determine how Medicaid eligibility could be verified if monthly ID cards are no longer issued.

Any physician who has comments on these issues should contact Jan Walters at 515/281-6555 by the end of this month. You may also mail comments to the DHS, Division of Medical Services, 5th floor, Hoover State Office Building, Des Moines, IA 50319.

Medicare access report from PPRC

The Physician Payment Review Commission (PPRC) recently released a report on access for Medicare patients. According to the report:

- Access to medical care is good for most Medicare patients, but vulnerable groups of patients (African-Americans, rural and urban poor) still have a problem. The biggest problem for these groups is access to preventive care.

- The percentage of assigned claims is over 90% nationally.

- 72% of all doctors are participating and 87% of all Medicare Part B claims are submitted by these doctors.

- 89% of all Medicare patients have some type of supplemental coverage. **IM**

Practice Management

Medical Business Specialist graduate

Mary Staub, office manager for Anthony Lazar, MD, Burlington, is the first graduate of the Medical Business Specialist (MBS) certification program. The program began in March of 1994 and consists of 10 medical business seminars. It is certified by the IMS and endorsed by the Iowa Medical Group Management Association (IMGMA).

Mary began the program March 18, 1994 and completed her courses June 21, 1995. She successfully completed all exams.

"The IMS Services MBS program has been great," Mary commented. "No matter how long you've worked for a physician, this program offers seminars that no technical school could do as well. I especially thank my sponsor/employer Dr. Anthony Lazar. I've accomplished my goal and he now has the first certified Medical Business Specialist in Iowa."

There are 52 enrollees in the MBS program. For more information, contact Sherry Johnson at IMS Services, 800/728-5398. **IM**



Mary Staub displays her MBS certificate.

MIDWEST MEDICAL INSURANCE COMPANY Focus on Risk Management

Malpractice gap

The underlying cause of many patient injuries and malpractice claims is the failure of clinics to implement and maintain systems to follow up on important information. You face almost certain liability if patient information that is, or should be, known to you "falls through the cracks" and an injury or failure to diagnose occurs as a result.

We call this the "malpractice gap". Common failures of follow-up systems seen in malpractice claims include:

- Failure to obtain results of diagnostic tests ordered.
- Failure to bring the results to the attention of the physician.
- Failure to notify patients of the test results.
- Failure to follow up on significant missed or cancelled appointments.

Clinic systems should be designed to consistently manage information, paperwork and records. Remember the Three Rs when designing your systems: **R**eceipt of information, **R**eview of information and **R**eport the information.

For further information, contact Lori Atkinson, MMIC risk management coordinator, MMIC West Des Moines office, PO Box 65790, West Des Moines, Iowa 50265, 800/798-9870 or 515/223-1482.

AT A GLANCE

Are you keeping up on developments with the Community Health Management Information System (CHMIS)? In less than one year, Iowa physician offices will be required by law to comply with CHMIS requirements. For the latest information and how it will affect your office, check out the editorial on page 317 by Terrence Briggs, MD, chair of the IMS CHMIS Committee.

There is still time to register for a seminar entitled "Survival Tactics in the Medical Office" being held in Omaha, West Des Moines and Cedar Rapids later this month. Jack McDermott will lead the discussion on administrative philosophies and adapting your management style to the practice. To register, call Sherry Johnson at IMS Services, 800/728-5398.

PRACTICE MANAGEMENT WORKSHOPS

QUALITY IN THE MEDICAL OFFICE

Wed., Sept. 6	Sioux City
Wed., Sept. 20	IMS headquarters
Wed., Sept. 27	Burlington Medical Center

This course examines trends in quality including outcome measures and practice parameters.

For more information or to register for any IMS practice management workshop, call Sherry Johnson at IMS Services, 515/223-2816 or 800/728-5398.

Newsmakers

AT A GLANCE

The University of Iowa Hospitals and Clinics has been named one of the nation's leading hospitals in a new edition of The Best Hospitals in America. The UHIC is one of only 74 hospitals in the U.S. listed in the book, published by Gale Research, Inc. Choices were based on recommendations of physicians from around the country and on information from government sources, professional and popular publications and surveys or interviews with about 150 hospitals.

The UI College of Medicine recently received the Silver Achievement Award of the American Academy of Family Physicians, in recognition of the fact that 32% of the graduating medical students in 1995 chose family practice as their specialty.

"Break the Silence, Begin the Cure"

Dear Editor:

We are returning the domestic abuse videotape you loaned us. At last, we as staff personnel, have been able to make the needed impression on our physicians.

This tape was used at a staff meeting. As office manager, I had on hand the poster, brochures and cards from the domestic violence break-out session of the IMGMA. At that time I was very impressed with the video and knew this would make a tremendous teaching staff meeting.

I have contacted the Domestic Violence Center and requested pamphlets and cards for our office. The Center has also given us additional ideas and suggestions for an ob/gyn office. We are excited that perhaps, in some small or unknown way, we have a chance to help someone in need.

Thank you for making this valuable videotape available. We highly recommend it for the medical profession.—*JoAnn McKinnon, office manager, Iowa Clinic, Des Moines.*

Editor's note: *The IMS domestic violence videotape is available for loan to any IMS member physician. Call Chris McMahon, director of communications at 515/223-1401 or 800/747-3070.*

Awards, appointments, etc.

Three new physicians have joined Medical Associates in Dubuque: **Dr. Mitchell Manthey**, internal medicine; **Dr. Mark Janes**, internal medicine and pulmonary medicine; and **Dr. Kim Riess-Sagers**, internal medicine and nephrology. Officials of Samaritan Health System, Clinton, recently played host to a number of Russian physicians and medical professionals as part of a medical personnel exchange

program which focuses on maternal and child health. Two Medical Associates physicians directly involved in this effort were **Dr. Robert Donnelly**, obstetrician/gynecologist and **Dr. Virgil Corpuz**, pediatrician and advisor for the Maternal/Child Health Program.

New members

Iowa City

Alicia Weissman, MD, family practice
Geralyn Zuercher, MD, family practice

Indianola

Gary Janssen, DO, family practice
Eileen May, DO, family practice

Knoxville

Alan Sooho, MD, psychiatry

Mason City

Michael Blackmore, MD, psychiatry
Katherine Broman, MD, family practice
Barbara Coulter-Smith, DO, obstetrics/gynecology
Robert Cunard, MD, resident
Shawn Griffin, MD, resident
Eric Stenberg, DO, resident
Julie Waddell, MD, resident
Michael Weston, MD, resident

Mt. Ayr

Yogesh Shah, MD, family practice

Mt. Vernon

Pamela Talley, MD, family practice

Onawa

Paul Dudley, MD, family practice

Ottumwa

Mark Dillon, MD, internal medicine/emergency medicine

Pella

Richard Posthuma, MD, family practice

Sioux City

Leslie Hershkowitz, MD, cardiology
 John Marriott, DO, radiology
 Lonnie Lanferman, DO, resident

Washington

Curtis Frier, DO, general practice
 Chung Huang, MD, internal medicine
 Lynette Iles, MD, family practice
 Rey Chyi Lin, MD, internal medicine
 Dennis Shimp, DO, general practice
 Paul Towner, MD, family practice

Waterloo


Richard Korentager, MD, plastic surgery
 Robert Miller, MD, cardiac surgery
 Alyce Tyree, DO, resident

Deceased members

Kenneth Dolan, MD, 66, radiology, Iowa City, died May 6

Edward Posner, MD, 76, life member, internal medicine, Des Moines, died February 14

Kerry Jensen, MD, 59, family practice, Clinton, died April 20

Edward DeLashmutter, MD, 71, general surgery, Fort Madison, died May 5 

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PHYSICIANS ON THE Front Line

They saw a side of World War II that even the soldiers didn't see. Retired Des Moines physicians Dr. Ralph Dorner, Dr. John Hess and Dr. Robert Stickler recall their harrowing experiences treating the wounded during the Allied invasion of Normandy and the Battle of the Bulge.

They never thought of themselves as heroes and, a lifetime later, their modesty survives intact.

"I told members of my surgical team that the important thing was to be able to sit in the quiet of our tents and decide we did the best job possible with what we had to work with," comments Dr. Ralph Dorner, a retired thoracic surgeon who landed on Utah Beach with the Third Auxiliary Surgical Group on June 7, 1944, D-Day plus one. "If we could do that, we didn't need to worry about decorations."

Dr. Dorner, Dr. John Hess and Dr. Robert Stickler were in the thick of the action treating wounded in World War II's European theater. They seem uncomfortable discussing ribbons and medals and relate their medical war stories quite dispassionately; but it's obvious the passage of time hasn't completely dimmed memories of fallen comrades and families waiting at home.

"The folks back home should have gotten medals," adds Dr. Dorner. "They never knew when we were in danger."

Dr. Dorner's trek toward Utah Beach began when he sailed for England in December, 1942. He was stationed at Oxford for a time, sent to Africa then back to England to prepare for D-Day after the Sicilian campaign was completed. Dr. Dorner's worst memory of the war was April 27, 1944 when he was in a convoy of seven landing crafts doing beach landing maneuvers.

"Three of our landing crafts were torpedoed by German E boats. There were 750 boys killed. It was terrible."

No x-rays, blood work or tables

When Dr. Dorner arrived on Utah Beach, he found one field hospital already set up. He helped set up another and was assigned to triage. Oddly, his first case was a soldier with appendicitis. He was on Normandy beach about eight days, then he and his team followed troops to the French village of Ste. Mere-Eglise, the first to fall to the Allies.

"We had no x-rays, no blood work, no lab work. We used universal blood which we had because of Dr. Bob Hardin at the University of Iowa. Our operating

"Triage was simple. If they couldn't be moved 30 miles, you did something for them."

Dr. Robert Stickler

CHRISTINE MCMAHON
Ms. McMahon is director of communications for the Iowa Medical Society and managing editor of Iowa Medicine.

tables were litters on sawhorses and we used lots of penathol.”

He recalls the difficulty of trying to operate in a tent with an American tank parked right outside engaged in non-stop shelling. One case Dr. Dorner particularly remembers was a soldier whose neck was laid open and his thyroid cartilage divided.

“It was a very unusual wound. I did a tracheotomy and patched him back together,” he recalls. “We saw lots of unusual land mine injuries. We did a lot of bowel resections for bowel lacerations.”

Air compressor becomes suction machine

He also recalls that there was plenty of ingenuity on the part of physicians.

“We had tent lights we made with plasma cans as reflectors, and I recall in Africa we went to a salvage dump looking for a suction machine. The captain of the dump reversed the tube on an air compressor with the swing of an ax and a swish of his knife — great suction. When we got ready to transport the tracheotomized patient, a corporal rigged up suction by hooking it to the windshield wiper apparatus on the ambulance.”

After Normandy, Dr. Dorner and the Third Auxiliary went “hedge hopping” from one field hospital to another, following Allied troops who were chasing the Germans.

In December of 1944, Dr. Dorner’s team was sent 12 miles east of Malmedy, Belgium, the center of the Ardennes bulge breakthrough by the Germans on December 17. Dr. Dorner and his team, in great jeopardy, somehow managed to evacuate themselves and their patients.

“I rode on the running board of an ambulance,” he relates. Dr. Dorner achieved the rank of major and is mentioned several times in *Front Line Surgeons*, a book containing eyewitness accounts by members

of the Third Auxiliary Surgical Group.

400-900 casualties a day

Dr. John Hess, a longtime Des Moines family physician, enlisted in the Army when he was a junior in medical school and went into officer training in June of 1942. He shipped out of Boston shortly before D-Day and was placed in reserve for the 82nd Airborne and the 102nd Airborne.

Within a few months, he found himself heading up a group of surgeons and other medical personnel at the Battle of the Bulge.

“We set up a hospital in an old army barracks near a small town in Belgium. We gave them blood, started IVs and shipped them out. We took care of whoever was brought in — even German soldiers,” Dr. Hess relates.

Then, they moved to a small Belgian hospital where they saw “terrible casualties, between 400 and 900 a day. One of my biggest problems was disciplining the officers not to spend time on people who were beyond help.”

Frostbite, leg ulcers

Common injuries were burns, broken bones, shrapnel and gunshot wounds — mostly from artillery. There was also plenty of frostbite and ulcers on legs from standing in foxholes in the snow.

The Battle of the Bulge unfolded in such a bewildering fashion, Dr. Hess relates, that even medical personnel “never knew how far

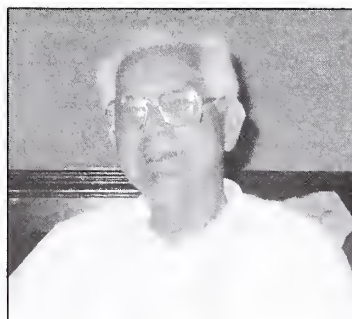
“*In the dim light of the tent, one casualty looked like another. Actually, no two were alike. There was no telling what the wounds would show, once the bloody blankets had been discarded and the clumsy dressings cut away. There might be just one small puncture wound or there might be a hundred jagged lacerations. One man with a tiny perforation in the flank might be in profound shock while the next one with part of his intestines out on the abdomen would nonchalantly ask for a cigarette.*”

From *Front Line Surgeons* by Clifford Graves.

continued



Dr. Ralph Dorner



Dr. John Hess



Dr. Robert Stickler

“There were casualties everywhere. Sixty members of our group of 240 were killed during the landing.”

Dr. John Hess

we were from the front lines”.

Dr. Hess was at the Battle of the Bulge for two weeks and was then sent back to France to prepare for an airborne mission across the Rhine into Germany. He and the other surgeons went in on gliders, an extremely risky business.

“After Normandy, very few doctors parachuted because in those conditions and without supplies or equipment, a doctor became little more than an aid man,” he says.

The morning of the glider mission, Dr. Hess had an emesis after breakfast. He assumed his nausea was caused by apprehension.

“We knew where we were going,” he recalls. “We knew it was going to be a bad deal. As we were flying over the woods, all I could see were muzzle blasts from 20 millimeter aircraft guns aimed right at us.”

Chest surgeon killed

The gliders landed under fire and Dr. Hess lay where he landed without moving for nearly an hour.

“There were casualties everywhere. Sixty members of our group of 240 were killed during the landing.”

One of those killed, he remembers, was a chest surgeon from Massachusetts General.

“There were no marks on him and we couldn’t figure out what had killed him until later when we examined him more closely. An explosive shell had entered his rectum and ruptured his aorta.”

Dr. Hess’ team set up a field hospital near a

schoolhouse and, within a few hours, Dr. Hess discovered why he had vomited the night before.

“I had hepatitis and didn’t even realize it until I urinated. I took an orange juice substitute, dug a fox hole and lined it with abandoned parachutes,” he says.

He stayed in the fox hole for three days, getting up only to make rounds twice a day. At night, he watched tracer bullets lighting up the sky above him. Finally, he was transported to a hospital in Le Mans, France, where he stayed for three months receiving the only hepatitis treatment available — rest and a proper diet.

By the time he had recuperated, the war was officially over and he was assigned to the 82nd Airborne occupying Berlin.

“I was with one of the first groups into Berlin. It was a pile of bricks.”

Conditions in Berlin were abysmal. Starving Berliners, shunned by rural Germans, did anything for food. Dr. Hess admits to being shocked by the ways some people took advantage of the others’ hardships. The Russians, he recalls, were particularly merciless to the displaced Germans.

To top it off, he was assigned a laundry woman who was “a dyed-in-the-wool Nazi”.

“She hated me and I felt the same about her,” he admits.

In October of 1945, Dr. Hess learned that he and other physicians might be sent home. However, the Russians informed the Allies

that, if they sent them home, they could not replace them in Berlin.

"So, instead of going home, I got a two-week leave in Switzerland. That was the first time I was able to call my wife and hear about our son who was born in February," says Dr. Hess.

Kept going until they ran out of gas

Dr. Robert Stickler, a Des Moines general surgeon, was called from reserve to active status after Pearl Harbor and was sent to France after the D-Day invasion.

"We worked out of trucks doing makeshift operations," he says. "Triage was simple. If they couldn't be transported 30 miles, you did something for them."

He says surgeons on the front line did no definitive bowel surgery.

"We resected the bowel, cut away the dead tissue and sewed them up. We did no vascular work, we just amputated."

Dr. Stickler and other surgeons tagged along behind Allied troops through France.

"We played leap frog with three trucks. One was our sterilizing unit, one was gearing up and the other was in operation," he explains. "We kept going until we ran out of gas and someone came along with a new supply."

Following the armored tanks was difficult because the Germans fired mortars at them continually. However, he doesn't recall being frightened.

"Fear was something that developed gradually as time went on. It's strange, but I didn't have any great anxiety until after the war was over."

Snow, isolation at the Battle of the Bulge

Eventually, Dr. Stickler was assigned to General George Patton's group, the 10th armored division, and ended up at the Battle of the Bulge.

"That was isolation. We couldn't even evacuate our wounded," he recalls.

In addition to the isolation and shortages of supplies, the weather was cold and snowy, making the conditions extremely difficult for working and living.

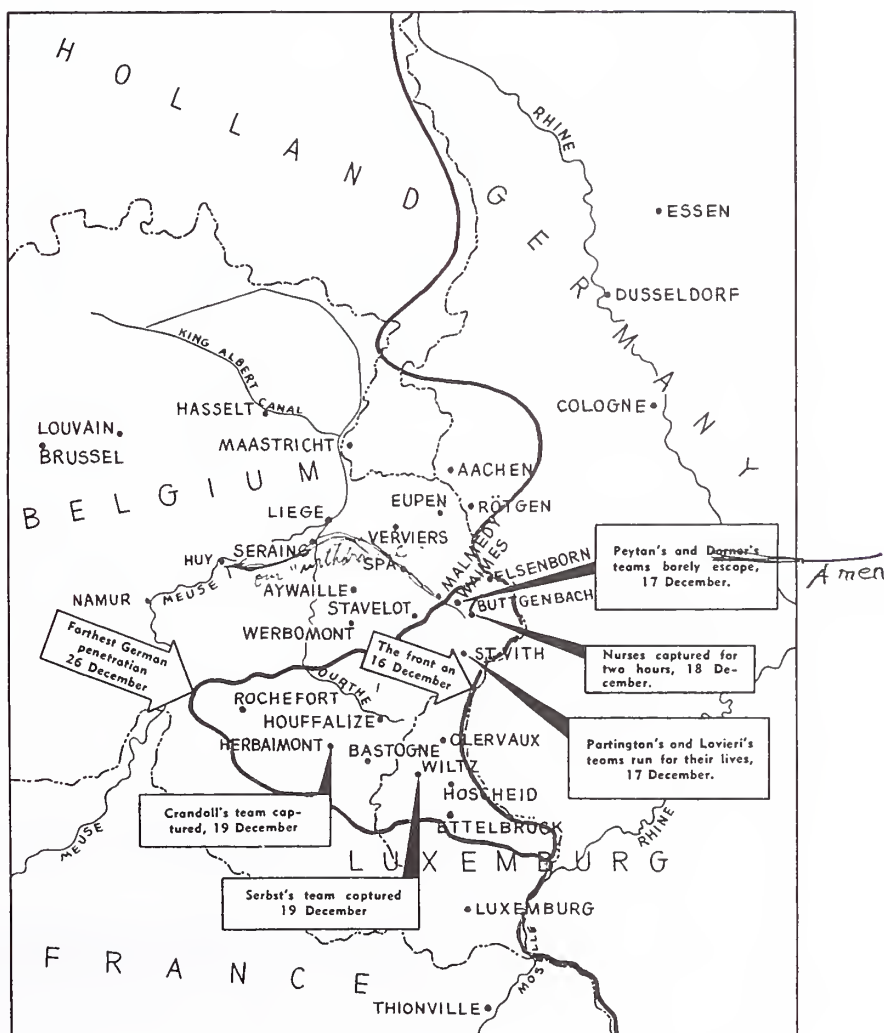
"We did without some of the frills . . . like gloves. We relied a great deal on sulfa crystals," he says. "In the field hospital, the first guys in got the best treatment."

Dr. Stickler and other surgeons treated wounded soldiers in chicken coups, next to stone walls, anyplace that offered a bare modicum of shelter or windbreak. How was he able to tolerate the physical hardships?

"I was young," he says with a smile. "One

continued

This map depicting the Battle of the Bulge is contained in a book called *Front Line Surgeons*. The book tells the story of the Third Auxiliary Surgical Group, of which Dr. Dorner was a member. The note on the map is Dr. Dorner's. Drs. Hess and Stickler were also at the Battle of the Bulge.



continued

thing I remember very well is receiving the *IMS Journal*. It was my major source of medical information."

Dr. Stickler admits to hating blackouts — which he remembers as "heavy and oppressive" — but he is philosophical about war.

"As you get into it, things are put into a different perspective. You lose your venger. I'm afraid there's no time to be nice."

Dr. Dorner kept a surgical diary which contained an account of each patient he treated.

3398		TRANSCRIPT		BCEU	
(a) 1					
2 Last name		3 First name and middle initial		4 A. S. No.	
WILSON		Grover C		35706128	
(b) 5 Grade		6 Company		7 Regiment and Arm or Service	
Pvt		G		314 Inf	
(b) 9 Race		10 Nativity		8 Age	
W		Ky		19	
(b) 11 Service		12 Date of admission			
11/12		30 Aug 44			
(b) 13 Source of admission					

14 Register numbers or hospital memoranda:

1. Shell wounds, (HE), left flank, multiple, severe, just above left iliac crest, entering abdomen and perforating small intestine in six (6) places, and descending colon in one (1) place.
2. Cecostomy, McBurney region, secondary to #1.
Incurred 8 Jul 44, about 2200 hours 2 miles from St. Lo, France while scouting during start of attack on enemy position, when injured by explosion of 88mm shell. WIA.

LD --- 1 & 2 Yes.

Evacuated to the Z of I - 9 Sep 44.

15 Name of Hospital

188 GH

(a) Fill in on: Register Index, Diagnosis Index, Disability Index, Death Index, Out-patient Index, or Venereal Report Card, as appropriate.
(b) Spaces 5 to 13 inclusive not to be filled in when form is used for Register Index in time of peace and in the Zone of the Interior in time of war.

Form 52a
MEDICAL DEPARTMENT, U. S. A.
(Revised March 15, 1938)

16-10719

ship bound for the Philippines. The ship got as far as the Caribbean when the war in the Pacific ended.

"I'll never forget the moment when the captain turned the ship around and we headed for home," he says.

The legacy of war

On his son's 40th birthday, Dr. Hess took him to Europe to visit many of the places he knew from war. Dr. Dorner attends periodic reunions of the Third Auxiliary Surgical Group and plans a visit to England and France in September. Dr. Stickler has not returned to Europe since he was discharged.

Dr. Hess "wouldn't want anyone to go through what I went through" but is glad he had the experience; Dr. Dorner "wouldn't give a nickel for the whole thing", but wouldn't give it up for a million dollars.

However, for Dr. Dorner, the most persistent legacy of the war is even simpler.

"Little things don't annoy me much," he says calmly. **IM**

Following the Battle of the Bulge, Dr. Stickler was assigned to the 7th Army and sent to the resort areas of Austria. His job was to look for German SS officers who were hiding in the hospitals.

"The German officers faked injuries so they could escape detection. I remember finding at least one," he says.

After he completed this assignment, he was sent to Paris to await transport back to America. Unfortunately, Uncle Sam wasn't finished with Dr. Stickler and he found himself on a

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**Don't miss out on this opportunity to learn more about domestic abuse in Iowa
and how you can help your patients.**

The Journal

of the Iowa Medical Society

Air pellet gun injury

● DANIEL WATERS, DO; BENJAMIN BROGHAMMER, MD; R. MARK DUFF, MD

A seven-year-old male sustained a compressed air pellet gun injury to the thorax at close range (<2 m). The child was brought to the emergency department (ED) at the local county hospital. Initial examination revealed an apprehensive child who exhibited some mild respiratory splinting, but no signs of respiratory distress. Blood pressure was 118/76 mm Hg with a respiratory rate of 28/min and a pulse rate of 106 bpm. Initial chest radiograph (see Figures 1a & 1b next page) revealed a radiopaque foreign body at the inferior left heart border. No pneumothorax was noted.

The patient was transferred to a regional referral facility. Examination in our ED revealed no change in hemodynamic status. An entrance wound was noted just lateral and inferior to the right nipple. There was no identifiable exit wound. The pellet could not be palpated beneath the skin of the thorax or abdomen. No paradoxical pulse was noted. Arterial blood gases on room air were normal. An electrocardiogram showed only sinus tachycardia. Repeat chest radiography showed no discernible change in the position of the pellet. Chest fluoroscopy in the anterior-posterior projection demonstrated the pellet to be "spinning" with cardiac motion. Changing the position of the patient did not change the position of the pellet.

Non-contrast computed tomography of the chest showed no evidence of pneumothorax and suggested that the pellet was located in the anterior mediastinum. Because of the significant amount of "scatter" created by the pellet, however, definitive location could not be determined. Two-dimensional echocardiography showed the pellet to be extracardiac but within the pericardium near the ventricular apex. There was no evidence of tampon-

ade or pericardial effusion.

The child was managed expectantly. Serial echocardiograms showed no change in pellet position and no pericardial fluid accumulation. Serial cardiac isoenzymes determinations were normal. The patient remained stable and asymptomatic and was discharged on the third hospital day. Follow-up chest x-ray at three and 14 months showed no change in the cardiac silhouette or the location of the missile. A subsequent magnetic resonance imaging study failed to visualize the lead pellet, despite a chest x-ray confirming its original position. The child remains well and asymptomatic.

Discussion

With the proliferation of high-powered, high-velocity weapons, especially in urban areas, the incidence of penetrating chest trauma in children has become more commonplace. It is a misconception that because missiles fired from pellet guns are not explosive powered, they are not capable of inducing serious physical injury. Thus, many such pneumatic weapons end up in the hands of children because adults may feel that they represent a lesser risk of physical danger. Multiple case reports in both the thoracic surgical and pediatric literature belie this assumption.¹⁻⁵

The ability of a given bullet, pellet or projectile to penetrate the body is generally determined by its muzzle velocity.⁴ Although pneumatic weapons (pellet guns, BB guns, etc.) are classified as low-velocity, they are associated with both morbidity and mortality. The perception of such weapons as toys is an unfortunate one.

Ballistic analysis has shown that an air

The IMS Education Fund has designated this article as the Henry Albert Scientific Presentation Award for August 1995.

DANIEL WATERS, DO
BENJAMIN
BROGHAMMER, MD
R. MARK DUFF, MD
The authors are with the Departments of Cardiothoracic Surgery, Radiology and Pediatrics, North Iowa Mercy Health Center, Mason City, Iowa.

Air pellet gun injury

continued

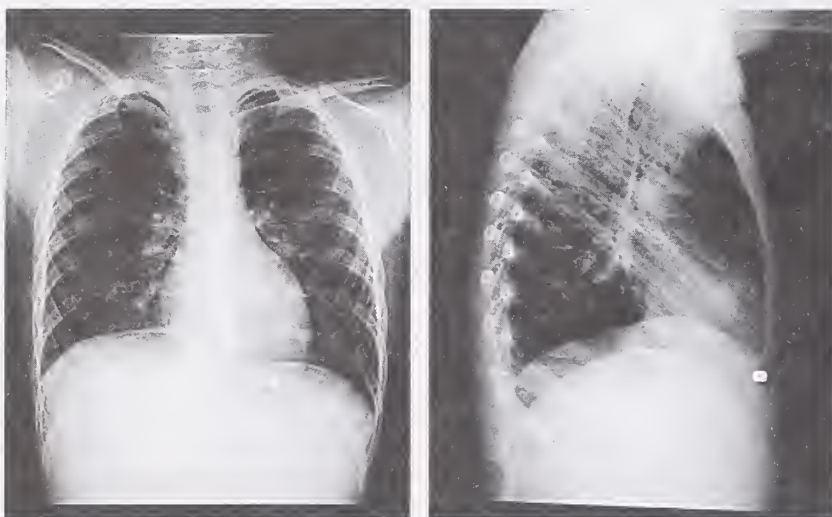


Figure 1. Posterior-anterior (a) and lateral (b) chest radiographs demonstrating pellet location.

rifle, if adequately pumped, can potentially produce a muzzle velocity of up to 900 feet per second (fps). It has been reported that a muzzle velocity of approximately 350 fps is sufficient to break the skin and cause damage in deeper soft tissue.⁴ Not only has death been reported as a result of pellet gun injury, but so has significant morbidity including ventricular laceration, cardiac tamponade, pneumothorax and cerebral and peripheral pellet embolization.¹⁻⁶ Small pellets within a left-sided cardiac chamber are more prone to embolizing to the cerebral circulation.⁶ Often, retrieval of a pellet and/or treatment of associated injury requires a major thoracic surgical procedure and the use of cardiopulmonary bypass.²⁻⁶

In the child who presents with severe hemodynamic or respiratory compromise, exact localization of the pellet becomes secondary to treatment of life-threatening injuries. In the minimally symptomatic child, however, accurate determination of projectile location is of great importance in determining both initial and long-term management. The standard chest radiograph, while it may indicate the presence of a penetrating cardiac or thoracic injury, is generally considered to be inadequate for localizing these projectiles.⁷ CT scanning is feasible, but is hampered by the variable amount of scattering of the radiation by a metallic projectile with resultant distortion of the radiographic images. Nuclear MRI may be useful in determining the location of non-ferrous missiles, but it is hampered by the fact

that often in the acute situation, the exact metallic composition of a given projectile is uncertain.⁸ Several reports have discussed the use of echocardiography as a means of accurately assessing not only pellet location, but also for diagnosing associated cardiac injury.^{7,9,10}


Perhaps the most important determination to be made in penetrating cardiac injury is whether the missile is intracardiac, intramyocardial or extracardiac. Intracardiac projectiles, i.e. those retained within one of the atria, ventricles or great vessels, are generally recommended for surgical removal. Some authors, however, recommended that a right-sided intracardiac missile which is not associated with other cardiac injuries does not necessarily have to be surgically extirpated. Left-sided intracardiac projectiles, because of the possibility of cerebral or peripheral embolization, are almost universally recommended for removal unless they are deeply embedded in the myocardium and not associated with other significant injuries.¹¹

Little has been written about projectiles which lodge within the pericardial space without associated cardiac injury. In the absence of hemodynamic or respiratory compromise, pericarditis or systemic infection, non-operative management—especially in the pediatric patient—may be preferable. Post-pericardiotomy syndrome has been reported with a retained foreign body, however.¹²

Conclusion

Air gun missile injuries in children can be associated with significant mortality and morbidity. For the clinician presented with a child who has sustained a chest wound from such a weapon, a high index of suspicion for occult cardiac or pulmonary injury must be maintained. The general adult public may not take the potential for injury from pneumatic weapons very seriously. Physicians must avoid the same mistake.

References

References noted in the article are available either from the authors or the editors of *Iowa Medicine*. 

Looking back and finding change

During recent months, war veterans have been reminded of World War II with tours and celebrations at Normandy Beach and surrounding countryside. Many American veterans have returned to the battlefields. Their hearts and minds have been filled with sad nostalgia, memories of their fallen comrades in arms and personal gratitude that they personally lived through that horrible historical event.

I, among many, was fortunate that I did not face combat during my years of active duty during World War II, as well as during the Korean Conflict. Though still in the Naval Reserve and subject to recall to active duty, I fortunately escaped the Vietnam War.

Recently while visiting our daughter in Seattle, I sought the locations of my active duty while there in 1951-1952. Our base was Pier 37 along the waterfront of downtown Seattle. At first glance I could not locate anything familiar. After 43 years, change had converted the nearby piers to shipping points for containerized cargo; no Navy facility present.

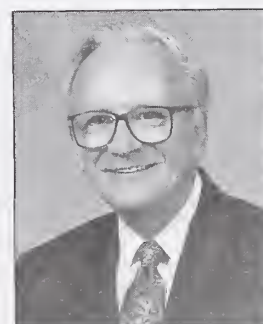
Then, I sought out the Navy Receiving Station where I was billeted when not at sea. Most of the facility was gone and the area was occupied by hundreds of new cars from Japan. The passing years had done it again. Alongside there was a large private marina where our daughter and her husband keep their boat.

Next, we went over to Bremerton, where I served some detached duty at the Naval Hospital. We did not go ashore, but the piers were packed with fighting ships in "moth balls." There lay the USS Missouri, USS Ranger, USS Nimitz, USS New Jersey, a number of destroyers and numerous submarines. One could not avoid thinking of what the officers and men experienced on those noble warships.

This type of adventure in nostalgia can be revealing. We oldsters can look back on how the practice of medicine was four to five decades ago. We can go back to high school and college reunions and renew old friendships. Too many of us live for the future and cast the past aside. That is

We oldsters can look back on how the practice of medicine was four to five decades ago.

unfortunate, because we experience rewards imprinted on our memories by living some of the past. Life becomes more full and we profit from such recall. Don't be caught in a rut along the pathways of the present; don't be disillusioned by perceived future events; live in the past as well to enrich your total life. Better yet, relate to your children and grandchildren stories of your past. At first they may think old grandpa is living too much in the past, but like all history the stories become more interesting with succeeding years. **IM**



MARION ALBERTS, MD

AMA DELEGATES DETERMINE MEDICINE'S AGENDA

The AMA House of Delegates—including the Iowa Medical Society's delegation—addressed a number of key health care issues at its annual meeting June 18-22 in Chicago. Following is a summary of actions. Members of the IMS delegation are Dr. Clarence Denser, Dr. Donald Young, Dr. Clarkson Kelly, Dr. Bruce Trimble, Dr. Daniel Youngblade, Dr. Thomas Graham, Dr. Bryan Pechous and Dr. Bernard Fallon.

Physician participation in capital punishment: evaluations of prisoner competence to be executed—This report concludes that physician participation in evaluations of a prisoner's competence to be executed is ethical only when certain safeguards are in place and that when a condemned prisoner has been declared incompetent to be executed, physicians should not treat the prisoner to restore competence unless a commutation order is issued before treatment begins.

Perinatal discharge of mothers and infants—Perinatal discharge of mothers and infants should be determined by the clinical judgement of attending physicians and not by economic considerations.

Professionalism and medical ethics—Resolved that the AMA reaffirm that the medical profession is solely responsible for establishing and maintaining medical ethics and that the state cannot legislate ethical standards or excuse physicians from their ethical obligations. Specifically, this resolution examines the AMA's opinion that it is unethical for health professionals to participate in state ordered executions.

Medicare transformation—The House of Delegates passed this amended report which outlines the AMA's proposal for transformation of the Medicare system. This platform will be used for negotiations with Congress in coming months. The report deals with a full spectrum of issues from limits on residency slots to cost sharing.

Criminalization of health care decision-making—The AMA opposes the criminalization of health care decision-making especially as represented by the current trend toward criminalization in malpractice; it interferes with appropriate decision-making and is a disservice to the American public. The AMA will educate opinion leaders, elected officials and the news media regarding the detrimental effect on health care resulting from the criminalization of decision-making.

Tobacco company liability—The AMA will oppose any provision of tort reform legislation that would give exclusion from liability or special protection to tobacco companies or tobacco products.

Medical specialty choice—The AMA supports measures to increase the availability of information on specialty choice to medical students and resident physicians by gathering and disseminating information on market demands and physician workforce needs for all specialties.

Nonphysician relations—The AMA reviewed its guidelines regarding the professional relationship between physicians and nurse practitioners/physician assistants. Discussion focused on adding and strengthening references to the supervisory responsibilities of physicians in all practice settings.

Violence against health care workers—The AMA House passed policy that supports the development of model state legislation to criminalize violence and threats of intimidation against all health care workers and their families.

In-line skating—In response to a dramatic increase in the number of in-line skaters and in-line skating accidents, the AMA House passed policy to recommend that all in-line skaters wear protective helmets, wrist guards, elbow and knee pads. Further, the policy recommends this safety equipment be available at the point of in-line skate rental or purchase and encourages efforts to educate adults and children about in-line skating safety.

Music rating system—In response to continued concern over the potential negative impact of destructive themes in some music, the House passed policy calling for the development of model state legislation to regulate the lyrical content and/or distribution of such music to individuals under age 18. The policy also calls for the AMA to work with the music industry to develop a rating system to identify recordings containing violent lyrics.

Physician hand washing—Observing the sesquicentennial of Semmelweis' observation that hands washed in chlorinated lime before examining patients reduced the spread of infection, the AMA reminded physicians that they have a professional obligation to wash their hands with an antiseptic before and between each patient encounter.

When physicians learn from colleagues

Note: This is the first of three articles on interdisciplinary CME. Subsequent articles will focus on physician learning from other health care disciplines and physician learning from other professions.

Planners of CME events and resources are continually in search of the correct denominator in marketing their wares. This is an easy task for the specialty societies. The CME content is directed to the level of expertise and interest of members of the particular society. While physicians who represent other specialties may be welcome to attend the conference or use the learning resource, the content is most likely to reflect developments and controversies within the sponsoring specialty.

The planning task becomes a greater challenge when the target audience includes more than one physician specialty. A number of questions emerge. Which specialty is the principal audience? Will the instructors also largely be members of that specialty? Is there an "agenda" through which one specialty is attempting to bring a message to another?

Never have such issues been so well illustrated as in planning for CME in the field of primary care. Primary medical care is not the sole province of any single specialty. There is controversy regarding what specialties are legitimate bearers of the title of primary care physician. Historically some CME primary


care programs have essentially been planned by one group of specialists for a second group or they have been developed by a specialty for that specialty and not for any other specialty!

Such approaches frustrate the opportunity for one specialist to learn from another who is in a different medical discipline. Advances in medical therapeutics then inevitably progress at varying rates within the clinical practices of the disciplines. Cross-fertilization is hindered, and in the worst scenario, the different disciplines adhere to contradictory practice standards that undermine the profession with the public.

Interdisciplinary CME is essential for pooling the broad experience of specialties in the prevention, evaluation and management of human disease. As CME consumers, physicians

Physicians can and should learn from their colleagues in other specialties.

should be alert to the signs of a healthy interdisciplinary offering. Is the conference or material publicized among multiple specialties? Do the planners represent the appropriate disciplines? Are the presenters at a conference representative of the target audience? Is discussion encouraged among the specialists?

Physicians can and should learn from their colleagues in other specialties. Look for the appropriate vehicle that facilitates such learning. 



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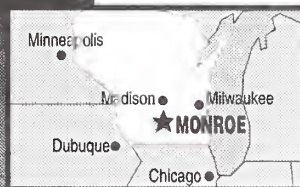
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R.K. Agarwal, MD

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515/223-8622

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Robert A. Colman, MD

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Cancer and Surgery of Skin*

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James D. Bunker, MD, FAAD

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Ravi K. Vemuri, MD
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24 Hours 515/224-1777

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General Internal Medicine
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Loren J. Mouw, MD

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Cedar Rapids 52401

319/366-0481

Practice limited to Neurosurgery

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Waterloo 50702

319/232-8756; fax 319/232-5703

Practice limited to Neurosurgery

Neurosurgical Services LLP

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Thomas A. Carlstrom, MD
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Cedar Rapids 52402
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Fort Dodge 50501
515/576-7777

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Cedar Falls 50613
319/277-0103

214 - 13th Street Southeast
Cedar Rapids 52403
319/362-8032

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Robert B. Goffstein, MD

Lyse S. Strnad, MD

John F. Stamler, MD, PhD

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Iowa City 52245

319/338-3623

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Bradley L. Isaak, MD

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P.O. Box 1877

Mason City 50401

515/423-8861

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United Federal Building

700 4th Street, Suite 305

Sioux City 51101

712/252-4333

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Ida Grove 51445

712/364-3311

Orange City Hospital

400 Central Avenue NW

Orange City 51041

712/737-2426

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Des Moines 50314

515/247-8400

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Fort Dodge 50501

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1215 Pleasant, Suite 408

Des Moines 50309

515/241-5780

1200 35th Street, Suite 200

West Des Moines 50266

515/225-7761

Satellite Clinics:

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Oskaloosa, Guthrie Center, Knoxville

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Daniel J. Blum, MD

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Marshalltown 50158

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516 South Division Street

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Otolaryngology-Head and Neck Surgery,

Facial Plastic Surgery, Allergy

(Continued next page)

Professional Listing Rates

Physician members of the Iowa Medical Society may advertise in this directory. Monthly rates are as follows: \$10.00 first 3 lines; \$2.00 each additional line. Billed yearly. May be prorated. Send or fax copy to Iowa Medical Society, 1001 Grand Avenue, West Des Moines, Iowa 50265-3599, fax 515/223-8420.

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Eugene Peterson, MD
Richard B. Merrick, MD
Peter V. Boesen, MD
Robert R. Updegraff, MD
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 Des Moines 50312
 515/274-9135

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James W. White, MD
Craig C. Herther, MD
Thomas J. Benda, Jr., MD
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 Dubuque 52001
 319/588-0506

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Douglas E. Dawson, MD
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 Iowa City 52245
 319/351-5680
 1-800/642-6217
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 Des Moines 50314
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Todd C. Troll, MD
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Yunker Rehabilitation Center
Iowa Methodist Medical Center
 1200 Pleasant
 Des Moines 50308
 515/241-6434

2600 Grand Avenue, Suite 102
 Des Moines 50312
 515/283-1570

Pulmonary Medicine**Fort Dodge Medical Center, PC**

Robert C. Ang, MD, FCCP
 800 Kenyon Road
 Fort Dodge 50501
 515/574-6820

Chest, Infectious Diseases & Critical Care Associates, PC

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Steven G. Berry, MD
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 Des Moines 50325-7072
 24 Hour 515/224-1777
Pulmonary Diseases

Surgery**Wendell Downing, MD**

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 Des Moines 50309
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Ralph E. Woodard, MD, FACS
Dan P. Warlick, MD, FACS
 800 Kenyon Road
 Fort Dodge 50501
 515/574-6865

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The corporatization of health care

A few weeks ago at the suggestion of a friend, I read an editorial titled, "Managed Care and the Morality of the Marketplace" (*NEJM*, July 6, 1995). I assumed the author—Dr. Kassirer—is from the Boston area, where the influence of HMOs, managed care organizations and large insurance companies is greater than in other parts of the country. His concerns, however, apply to all physicians. Unfortunately, the key motivation of some large insurance companies and corporations is not the care of the patient but the financial health of the business entity.

Should health care be subjected to the values of the marketplace? This could be the fundamental question for those of us in medicine.

Market-driven health care ultimately creates conflict that threatens our professionalism, says Dr. Kassirer. Doctors are expected to do all they can to help patients, using the best available tests and treatment. On the other hand, there is constant pressure to cut costs and limit services. As this scenario is played out, the doctor ultimately may be forced to choose between the best interest of the patient and their own economic survival.

In his article, Dr. Kassirer makes some assumptions: 1) Cost and not quality will dominate in the marketplace because quality is much more difficult to measure than cost;

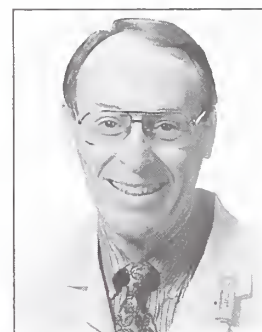
2) All plans will offer fewer services and even the best will trim benefits; and 3) Physicians (who else?) will be given the responsibility to implement these restrictions. This pits their duty to their patients against their duty to the payer or the employer. Once again we see the basis of the argument against the practice of medicine by a non-medical corporation. That battle appears to be lost.

This also points out the importance of physicians' participation in the formulation of policy used by various health care organizations.

I have no doubt that greater efficiencies can be found and implemented in the delivery of health care. While market distribution may work well for many goods and services, I don't believe that health care is a commodity and that the corporatization of health care is appropriate.

Physicians have a professional and moral responsibility to care for their patients. When patients are ill, they are vulnerable and looking for help. The patient needs to know that the doctor is on their side and that his or her concern for patients will override any financial consideration.

As Dr. Kassirer says, "After all, what oath, promise or pledge did we ever make either as an individual or as a professional that obligates us to restrict care? We pledged instead to provide care." **IM**



JOSEPH HALL, MD

**This pits
their duty
to their patients
against their duty
to the payer or
the employer.**

IMS Update

AT A GLANCE

The Mahaska County Medical Society Alliance continues its campaign to stop teenage pregnancy with distribution of the "Baby Think It Over" doll. The doll, which will not stop crying until it is picked up and "fed" with a feeding plug, can be purchased for \$250 and donated to an Iowa school. For more information, call Karen Messamer, IMSA president-elect, at 515/673-3751.

A new study in New Orleans shows that poverty — not race — accounts for the sharply higher incidence of domestic homicide among blacks. The study, published in JAMA, found that the sixfold difference in black and white rates of domestic homicide disappeared when household crowding was used as a measure of socioeconomic status.

National violence conference registration

Any physician or other health care professional can register now for "Bridging Science and Program", a national violence prevention conference scheduled for October 22-25 at the Des Moines Convention Center.

The conference will bring together scientists and practitioners who work toward violence prevention in family and intimate violence, youth violence, workplace violence and suicide prevention. Between 500 and 800 participants from across the country are expected, including Vice President Al Gore.

Registration is \$50. For more information, call the national conference organizers at 404/488-4647 or fax 404/488-4349.

Career satisfaction survey

Fifty-five percent of physicians would choose their profession again, according to the results of a University of Northern Iowa survey. The survey compared career satisfaction rates of physicians, dentists and teachers.

According to the survey, 32% of physicians would not choose their profession again. The remaining 13% were undecided.

In addition, 32% of physicians said they would encourage their children to pursue a career as a physician; 50% would not.

Free materials on several subjects

Healthy babies — The Iowa Substance Abuse Information Center has available a video entitled "I'm Having a Baby" available for physician offices. The video was filmed in Iowa and features local experts as well as the adoptive mother of two crack babies.

To order a complimentary copy, call 800/237-0614.

Flu shots — The Health Care Financing Administration has embarked on a campaign to educate Medicare beneficiaries about the value of flu shots. As part of the campaign,

patient brochures are available by calling HCFA's regional office at 816/426-6317.

Violence — The AMA Alliance has published a program kit for its nationwide anti-violence campaign. The 52-page packet outlines how to plan and implement many types of anti-violence events. To receive a program kit, call the AMA Alliance at 312/464-4470.

IMS dues statements

The first Iowa Medical Society dues statements will go out in early October. Iowa is unified at the state and county levels. Prompt payment of your dues will be greatly appreciated. **IM**

SPECIALTY SOCIETY UPDATE

The American College of Cardiology, Iowa Chapter, will hold its annual meeting September 16, 10 a.m. to 4 p.m., in Iowa City.

The IMGMA Fall Meeting will be September 13-15 at the Village East in Lake Okoboji.

The Iowa Psychiatric Society Executive Council recently discussed the need to raise annual IPS dues. Significant advocacy in the new managed care environment this past year has necessitated legal work and greater involvement with third party payers. Also, Medco has announced that a new outpatient treatment request form is now available on diskette. Call Medco, 515/223-0306.

The Iowa Association of County Medical Examiners Board of Directors met July 21 to make plans for their fall meeting on Friday, November 3 at the Sheraton Inn in Cedar Rapids. At the meeting, Dr. RC Wooters, Polk County medical examiner emeritus, will be honored. The next IACME Board meeting will be September 29 at the IMS.

The Iowa Oncology Society annual meeting will be October 27 at the McFarland Clinic in Ames.

The Iowa Association of Pathologists will meet in conjunction with the annual Iowa Anatomic Pathology course on September 15 and 16 in conjunction with the UI College of Medicine. The meeting will be at the Iowa City Holiday Inn.

FOCUS ON IMS ALLIANCE

In June I had the privilege of attending the AMA Alliance Annual Meeting at the Drake Hotel. The Alliance is moving forward on SAVE Today (Stop America's Violence Everywhere) which will be held annually on the second Wednesday of October, beginning October 11, 1995.

Every Medical Alliance in the nation is urged to do something on that day to focus attention on this devastating social problem that robs so many Americans of quality living.

Our project in Iowa is in the planning stages. If you have any projects you would like to suggest or worthy organizations for us to contact for help, please call us at the Iowa Medical Society headquarters, 1-800/747-3070. At the Alliance's July summer board meeting the enthusiasm throughout the state was wonderful.

Please help us with this worthy project as you hear about it in your office and through the media in the coming months.

Contributed by Linda Miller, president, IMSA

CLARKSON MEDICAL LECTURE SERIES

November 17, 1995
8:00 a.m. - 5:00 p.m.

Advances in Primary Care: Building on the Legacy

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sheet on Medicare
developed by the
Iowa Medical
Society.

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Between 90 and 180 days, the value of past due
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Futures

AT A GLANCE

Mutual of Omaha of South Dakota, in conjunction with a hospital and two physician clinics, recently launched the state's second major HMO. It covers 1,000 lives in Sioux Falls and plans to cover 5,000 by the end of 1995. The HMO's primary competition is DakotaCare, the HMO sponsored by the state medical society.

According to a recent edition of CBS News "Eye On America", HMO executives are paid nearly twice the average of CEOs in companies of comparable size. Norman Payson, HealthSource CEO, is the highest paid HMO executive, earning \$15 million last year. None of the top-earning CEOs whose salaries were discussed agreed to be interviewed by CBS.

Managed care legislation in California

Several pieces of legislation aimed at regulating the managed care industry in California are awaiting California Senate approval. These bills have the support of the California Medical Association.

If enacted, the bills would require health plans to provide more coverage for experimental treatments, force managed care networks to admit additional doctors at patients' requests and expand the liability of managed care and utilization review organizations. Political observers say there is a definite anti-managed care mood among California lawmakers.

Incremental reform has life

There are several indications that efforts are not dead to move incremental health reform forward this Congress. Nancy Kassebaum, Senate Labor Committee chair, along with Ted Kennedy and 10 other Labor Committee members, have introduced a "consensus" incremental bill.

The bill would limit exclusions for preexisting conditions, guarantee availability and renewability, increase purchasing clout of individuals and small employers and provide for state flexibility to enact reforms providing additional consumer protection.

According to a recent *Wall Street Journal*

editorial, President Clinton has also boosted the odds that some moderate health care changes may be enacted this year.

The president has accomplished this, said the *Journal*, "by drastically lowering his sights on overhauling health care and tucking his proposal into the big budget envelope".

The proposals put forth by the president would help small businesses afford insurance, provide subsidies for family breadwinners who lose their job and bar insurers from denying coverage to people with preexisting health problems.

Rep. Pete Stark of California was highly critical of the president's proposal. "I think it sucks. It's less than the Republican plans he was attacking last year."

The president's bill also contains another round of cuts in Medicare reimbursement for physicians. This proposal has been criticized by the AMA, though more diplomatically.

Going directly to physicians

Minnesota's Business Health Care Action Group is planning to begin direct contracting with physicians and hospitals in 1997.

The group has contained health costs among 24 member companies by encouraging competition among plans. In 1994, the firms averaged a 3.6% growth in health costs compared to a national average of over 7%. **IM**

PHO CASE STUDY REPORT AVAILABLE FROM MICHIGAN STATE MEDICAL SOCIETY

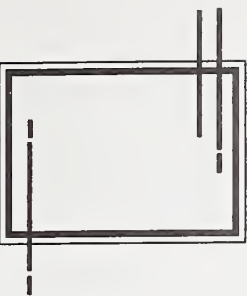
A PHO case study report of nine physician organizations around the US is available from the Michigan State Medical Society. The case study report was developed by the MSMS, the AMA and the Indiana State Medical Association.

The report examines many issues concerning PO development and operations, including how much money is needed to capitalize a PO, how to engender physician commitment, whether primary care-only or

specialist-only POs are viable and key elements of an effective management system.

To order a copy of the report, call (517) 336-7594 or write to the Michigan State Medical Society, Attn: Shannon Stockwell, 120 West Saginaw, PO Box 950, East Lansing, MI 48826-0950.

The cost of the report is \$25 for AMA members and \$95 for nonmembers. Visa and Mastercard will be accepted.



How to Collect for Control

An advanced training seminar designed to improve your success in preventing and collecting medical accounts receivable.

October 3

Omaha, Nebraska
Red Lion Inn
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October 4

Des Moines, Iowa
Best Western International
Terrace Room #4
1810 Army Post Road

October 5

Cedar Rapids, Iowa
St. Luke's Hospital
Medical Office Plaza
Rooms 2 & 3

- ? A patient arrives on Friday afternoon with an "emergency." This patient's account has already been sent to a collection agency because all efforts to collect have failed. How do you treat this person? What if it were a new account? A good customer?
- ? A divorced mother brings her child for services and asks you to bill the father for treatment. What if the accompanying parent is the custodial parent? Who is responsible for payment of the services? Should you request a copy of the divorce decree?
- ? The insurance company has sent the payment for services to the patient rather than your office. How do you get the check? What if the payment is for a lesser amount and it states that your fees are UCR? What if you have a contract with that insurance agency?

Do you know the answers to these questions? If not, you could be at risk for violation of the law—and fail to collect payment for the services you have provided. It is important to understand the legal limits of your position, how and when to finalize your accounts receivable and how to manage a healthy cash flow from your office.

IN ONE DAY WE WILL SHOW YOU HOW TO:

Control Systems

- ◆ Build a complete collection system
- ◆ Design an internal and external plan that works

Preventative Steps to Eliminate Collection Problems

- ◆ Create an effective financial policy for a sound foundation
- ◆ Utilize your best sources of information
- ◆ Identify potential problem payers
- ◆ Collect from insurance companies and attorneys quicker and with greater results
- ◆ Design collection letters with third-party influence

Effective Collection Call Planning

- ◆ Script your calls for greater effectiveness
- ◆ Set objectives before each call
- ◆ Choose specific words for the greatest effect
- ◆ Identify sources to obtain payment in full

Collection Calls for Control that Produce Results

- ◆ Handle stalls and objections more creatively
- ◆ Influence others to make and keep payment commitments
- ◆ Collect with third-party influence
- ◆ Stay in control of the telephone call
- ◆ Know how and when to finalize delinquent accounts

FACULTY

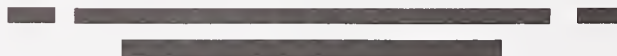


JEFF STAADS is a nationally known consultant and trainer, with extensive experience in health care operations and management. He is a master of collections, a motivational trainer and an instructor of collection strategies. As President of The Business Resource Center (BRC) for the past five years, Mr. Staads has developed the company's training and consulting programs. BRC provides both consultation and seminars for leadership/management, personal skills development and business/association development.

The professional associations for whom he has provided training and development programs include: American Academy of Dental Group Practice, American Association of Medical Assistants, Arizona Medical Association, Detroit District Dental Society, Indiana Dental Association, Kimberly Quality Care, Medical-Dental-Hospital Bureaus of America, Metro Omaha Medical Society, Oregon Society of Medical Assistants, Southern Medical Association, Special-

ized Pharmacy, State Medical Society of Wisconsin, Tennessee Medical Association, Texas Hospital Association, Washington State Dental Association, the Yankee Dental Congress and the Wisconsin Clinic Credit Managers Association.

Mr. Staads is adept and knowledgeable with the many facets of collecting including patients and third-party insurers. In addition, he has the ability to motivate managers and staff to be enthusiastic about collections and to improve their self-concept with practical tools that ensure success. Mr. Staads combines humor with expertise in this one-day workshop to improve the prevention and collection of your receivables.



"I was certainly impressed with your dynamic presentation style and ability to keep the audience interested and involved throughout the entire day. Participants appeared 'charged up' and excited about going back to their jobs to implement your ideas and suggestions."

Karen Garrett, director of practice management training
State Medical Society of Wisconsin

"Excellent program and speaker—I enjoyed it immensely while learning practical suggestions and new procedures."

Diane Marshall, CMA, office manager
Des Moines

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CHMIS Update

As part of the Iowa Medical Society's ongoing effort to educate Iowa physicians about the Community Health Management Information System (CHMIS), this CHMIS Update page will be a regular feature in *Iowa Medicine*.

Steady progress continues toward the July 1, 1996 implementation date for the Community Health Management Information System (CHMIS). The CHMIS Governing Board met July 21 and received the following updates from advisory committees considering various aspects of CHMIS implementation:

Quality Review — The final draft of the data dictionary was presented and approved by the Governing Board. This is an evolving document which defines data elements to be captured by the data repository. The document also defines the origin of the data elements (specific boxes on the HCFA 1500, the UB 92, remittance advice, etc.). The Governing Board approved the advisory committee recommendation that all providers and payers adhere to the federal coding guidelines with respect to V-codes.

Data — This advisory committee has appointed three task forces to resolve specific issues — 1) definition of the data elements to be collected by the data repository for retail pharmacy claims; 2) design of patient satisfaction and health status surveys; and 3) standard reports to be distributed from the CHMIS data repository.

Since the Governing Board has decided it will not release patient or provider-specific reports, one task force recommends that providers and payers have the ability to review their data in the data repository prior to release or sale of the data. This will ensure accuracy of the data. Other third parties may purchase the data base to produce provider-specific reports. The Governing Board approved the inclusion of worker's compensation information from the insurance claim form.

Technical — CHMIS networks will collect data to be fed into the data repository. The task force developing network certification criteria received a slight setback.

The group had been revising national standards from the Electronic Healthcare Network Accreditation Commission (EHNAC), adapting them to conform to specific Iowa CHMIS requirements. EHNAC now says they do not want their standards revised. As a result, CHMIS will use the original EHNAC standards as the first step in a network certification process, then mandate additional criteria for certification as an Iowa CHMIS network.

Another task force is developing a Request For Proposal (RFP) for vendors to bid on the data repository. This RFP is expected to be approved this month by the Governing Board. Vendors will likely have 60 days to submit bids. A contract probably won't be awarded before mid-December at the earliest.

The Governing Board has decided that social security numbers will be used to track and match patient data in the repository.

Committee appointments — Bonnie Steege, an employee of John Deere Waterloo Works, has been appointed to fill one of two vacant seats on the CHMIS Governing Board.

The IMS is seeking physicians who are interested in serving on advisory committees as vacancies occur. Contact Ed Whitver of the IMS staff if you are interested. IMS physicians involved in the CHMIS process continue to advocate key issues from the IMS statement of policy on CHMIS. Current discussions involve electronic insurance eligibility verification, time frame for other providers to begin CHMIS participation and universal acceptance of V-codes.

Because there is currently no CHMIS newsletter, the best way to stay informed on CHMIS developments is to read this monthly CHMIS update page in *Iowa Medicine*.

YOUR representatives on state CHMIS committees:

CHMIS Governing Board:

Dale Andringa, MD
Des Moines
515/241-4102

Beth Bruening, MD
Sioux City
712/233-1529

CHMIS advisory committees:

Communications/Education
Laine Dvorak, MD

Data Advisory
William Bonney, MD
John Brinkman, MD

Ethics/Confidentiality
Charles Jons, MD

Quality Review
Elie Saikaly, MD
William Langley, MD

Technical Advisory
Mark Purtle, MD

IMS CHMIS Committee:

Terrence Briggs, MD (chair)

IMS staff:
Ed Whitver
Barb Heck
Dean Gillaspey

Legislative Affairs

AT A GLANCE

In a recent interview, James Todd, MD, AMA executive vice president, criticized one aspect of President Clinton's proposed health care policy. Dr. Todd said the president's plan to balance the budget by sharply restricting Medicare payments to doctors, hospitals and nursing homes is un-sound because there is no "shared sacrifice".

Washington insiders say the president will veto some of the 13 spending bills to protest cuts in appropriations for certain programs. In some cases, the GOP won't have the two-thirds votes necessary to override a veto, so there will be more deal-making and a massive spending/tax package around Thanksgiving. The deal will sharply slow the growth of federal spending over the next seven years.

IMS preparing for 1996 Legislature

The IMS Committee on Legislation will meet September 12 and November 28 to discuss recommendations for 1996 legislative priorities. The committee's recommendations will go to the IMS Board of Trustees for final approval.

Specialty societies are encouraged to bring issues of concern to the committee's attention through their representatives on the committee. IMS members may also contact Kevin Cunningham, MD, committee chair; Clarence Denser Jr., MD, vice chair or Becky Roorda, IMS staff.

IMS Committee on Legislation

Kevin Cunningham, MD, chair
Clarence Denser, Jr., MD, vice chair
Ralph Beckett, MD, thoracic society
Christopher Blodi, MD, ophthalmology
John Canady, MD, plastic surgery
David Carlyle, MD, family practice
David Coster, MD, general surgery
William de Gravelles, MD, rehabilitation medicine
Judith Dillman, MD, anesthesiology
Steve Eyanson, MD, internal medicine (ACP)
Tom Gellhaus, MD, obstetrics/gynecology

Robert Gitchell, MD, orthopedic surgery
Jerry Lewis, MD, psychiatry
Edward Loeb, MD, pathology
Dean Lyons, MD, otolaryngology
Randall Maharry, MD, dermatology
Dennis Mallory, DO, county medical examiners
Roscoe Morton, MD, oncology
Edward Nassif, MD, allergy
Richard Nelson, MD, UI College of Medicine
Steven Phillips, MD cardiology
Kenneth Schultheis, DO, emergency medicine
Rizwan Shah, MD pediatrics
John Shierholz, MD radiology
Paul Sosnouski, MD, internal medicine (ASIM)
Kent Svestka, MD, family practice
Steven Wolfe, MD, family practice
Pam Smits, IMS Alliance
Pat Buelow, Iowa Medical Group Management Association

Pharmacist drug therapy management

The Iowa Board of Pharmacy Examiners has proposed administrative rules to allow pharmacists to provide drug therapy management, including initiation of drug therapy and therapeutic interchange, under protocol or guidelines from a prescribing practitioner.

The IMS has submitted comments oppos-

CONTRACT WITH AMERICA SCORECARD AND OUTLOOK

A recent Kiplinger Newsletter contained the following scorecard of the status and possible outcome of initiatives contained in the Republican Contract with America.

Proposal	House	Senate	Outlook
Property rights compensation	Passed	Pending	Probably won't make it
Regulatory reforms	Passed	Pending	Watered down, if anything
Tax cuts	Passed	Pending	Probably modest cuts
Welfare reform	Passed	Pending	Still up in the air
Crime bill	Passed	Pending	Probably will pass
Product-liability limits	Passed	Passed	Might die in conference
Line-item veto	Passed	Passed	Will be delayed awhile
Balanced budget amendment	Passed	Defeated	Maybe next year
Congressional reforms	Passed	Passed	Signed into law
Curbs on unfunded mandates	Passed	Passed	Signed into law
Term limits amendment	Defeated	No action	Forget about it

ing the rules as drafted because they would have the effect of allowing pharmacists to practice medicine and physicians do not have the legal authority to delegate such activities to individuals not under their direct supervision.

The Board of Pharmacy Examiners does not regulate physicians. The Iowa State Board of Medical Examiners would be responsible for determining whether such authority could be delegated by physicians.

The Iowa Administrative Rules Review Committee has requested an attorney general's opinion on whether the Board of Pharmacy Examiners has the legal authority to make such a major change in practice through the administrative rules process rather than through legislation.

While such opinions are not legally binding, the attorney general functions as legal counsel for state agencies; failure to follow legal counsel's advice would occur only in highly unusual circumstances.

IMS/AMA policy states that the practice of therapeutic interchange is acceptable only in inpatient hospitals and selected similarly organized outpatient settings that have an organized medical staff and a functioning pharmacy and therapeutics committee.

The system must: 1) have the concurrence of the organized medical staff; 2) provide detailed methods and criteria for the selection and objective evaluation of pharmaceuticals to be used; 3) have policies for continuous and comprehensive review of the drugs which may be substituted; 4) provide a method to monitor compliance with the protocol and clinical outcomes where substitution has occurred and to intercede where indicated and; 5) provide a mechanism that allows the prescribing physician to override the system when necessary for an individual patient without inappropriate administrative burden.

The IMS plans to discuss the issue with representatives of the Iowa Pharmacists Association to determine if there is a way to facilitate communication between physicians and pharmacists in caring for patients.

Call Becky Roorda at IMS, 515/223-1401 or 800/747-3070, for more information. **IM**

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Medical Economics

AT A GLANCE

Watch your mail for materials provided by the Iowa Medical Society for physicians whose patients are confused about Medicare reform. The IMS has created a one-page Q & A piece (suitable for copying) which is geared for patients and discusses basic Medicare issues. A synopsis of the AMA's Medicare proposals will also be sent to IMS members.

A recent survey by the Iowa Department of Public Health shows childhood immunization rates in Iowa have significantly increased. The survey shows that 77% of two-year-olds are fully immunized, up from 50% reported in 1993.

Obstetrical stays — IMS, AMA policy

Members of the IMS Committee on Maternal and Child Health plan to discuss the issue of how long women should stay in the hospital following vaginal and C-section births.

Major insurers including two in Iowa announced plans to limit payment for hospitalization after normal delivery of a baby to 24 hours unless additional time is approved, causing a major flap in the media and widespread public criticism.

In the wake of these announcements, a bill was introduced in the US Senate requiring health insurers to allow mothers and newborns to stay in the hospital at least 48 hours after delivery.

Meanwhile, in the *Des Moines Register*, a spokesperson for Principal Health Care of Iowa said that company will delay until January 1 any changes in the number of obstetrical days. Principal had planned to implement hospital stay limits for new mothers on August 1.

Delegates to the AMA House of Delegates this June approved a new policy regarding postpartum hospital stays. The new policy expresses concern that there is an absence of data to demonstrate that brief perinatal hospital stays are safe for babies and mothers. The delegates said that the length of stay should be determined by the clinical judgment of attending physicians.

The AMA has not called for legislation to mandate payment for a specific length of stay due to concerns that such laws legislate the practice of medicine.

This issue will be discussed by the IMS Committee on Maternal and Child Health. The IMS will participate in a study of the issue by the Infant Mortality Review Panel led by Herman Hein, MD. Dr. Hein is a member of the IMS Committee on Maternal and Child Health and a nationally-renowned expert on infant mortality.

Blue Cross Blue Shield has indicated they will be flexible in implementing payment policy, will rely heavily on the clinical judgment of physicians who recommend longer stays for patients and will pay for a home visit after discharge.

The IMS plans to discuss these issues further with Principal and other payers.

Fee schedule adjustment

HCFA has decided to achieve budget neutrality in the Medicare fee schedule by adjusting the conversion factor rather than the relative value units. HCFA hopes to begin using the CFs January 1, 1996 as part of its fee schedule proposals.

The adjustment will mean little difference in physician reimbursement.

To date, HCFA has simply trimmed all RVUs across the board to achieve budget neutrality requirements. Groups such as AMA and the PPRC asked HCFA to use the conversion factor in order to maintain the integrity of the system. Until this year, HCFA said it lacked authority to do so.

Other proposed Medicare payment and policy changes for 1996 were published in the Federal Register. To comment on the proposed changes, mail written comments (one original and three copies) to: HCFA, Dept. of Health and Human Services, Attn: BPD-827-P, PO Box 7519, Baltimore, MD 21207-0519. Comments must be received by September 25, 1995.

Hospitals win Minnesota tax litigation

Hospital associations in Iowa, North Dakota, South Dakota and Wisconsin have been notified that a court ruling regarding the MinnesotaCare tax has gone in their favor. A lawsuit filed by the AMA and the IMS on behalf of physicians in states bordering Minnesota was also successful.

The state of Minnesota is now permanently barred from collecting the MinnesotaCare tax from either hospitals or physicians which treat Minnesota patients.

Court rules for AMA, medical societies

A federal court has ruled in favor of AMA, the Medical Society of New York and three county societies in New York in an antitrust suit filed by a group of chiropractors.

The suit, filed in 1993, charged that the medical organizations, several HMOs and the Health Insurance Association of America had conspired to block chiropractors' access to managed care plans.

A US District Court judge threw out all the claims against the medical societies and denied the plaintiffs permission to replead their case. The court declined to dismiss the claims against the HMOs and the HIAA.

The judge termed "ludicrous" the chiropractors' claim that the AMA had monopolized the market for medical information. **IM**

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Practice Management

AT A GLANCE

Be careful what you ask job applicants — you might run afoul of EEOC, which enforces the disabilities law. You can't ask if an applicant has AIDS, has ever filed a workers' comp claim, is on medication or has been treated for substance abuse or depression. However, it is okay to ask about performance and whether they can handle tasks that are essential to doing the job.

OSHA will hound companies with bad safety records under a program that will go nationwide in 1996. Regulators will use workers' comp records and other data to spot the worst offenders. However, there will be fewer inspections of companies with clean records.

IRS crackdown on mismatched ID numbers

Federal law requires that a 1099-MISC form be filed for each person or corporation to whom an entity paid at least \$600 in medical payments. The doctor's name and Taxpayer Identification Number (TIN) must be on the 1099-MISC form when it is submitted to the IRS.

The IRS implemented a TIN verification system for doctors because of mismatches with doctor names and TINs. Mismatches occur for reasons including: affiliated doctors or clinics use the same TIN; practice groups use one TIN for multiple sites with different names; inconsistent use of TINs between group practice and individual practice; inconsistent use of abbreviations for names.

Under the IRS TIN verification system, the IRS requests employers and other payers to correct doctor taxpayer ID numbers that appear on the 1099-MISC forms. Employers do this by sending an IRS form and an IRS letter to the doctor. If an employer receives a second notice from the IRS on the same doctor within a three-year period, employers must mail the notice directly to the doctor and begin withholding 31% of all future payments to that doctor.

Employers may not stop withholding from reimbursements until the IRS says the doctor has provided a correct TIN. Doctors should be sure to respond to any TIN inquiries to be sure the correct information is in the system.

More waived tests under CLIA revisions

Admitting it is unlikely that the Clinical Laboratory Improvement Amendments (CLIA) will stay in place with no changes, HCFA has put forth a four-point proposal to revamp CLIA. However, it may not be enough to satisfy congressional Republicans who hope to erase the law from the books.

The CLIA plan is one of six regulations HCFA found in need of change in response to

President Clinton's call for agencies to reinvent health care regulations. Following are the four changes HCFA proposes:

- Expand the waiver criteria and streamline the waiver process to waive more tests. Requirements would be waived for tests that do not require trained personnel. *(Proposed rule published this month.)*

- Waive the routine two-year survey of "black box" technology users; conduct surveys only if a problem is indicated. HCFA will develop the criteria to determine which technologies qualify for the waiver. *(Proposed rule to be published this month.)*

- Use performance standards and require less frequent on-site inspections of "excellent performers". Private accrediting organizations may be approved to accredit labs when their standards meet CLIA's. Also, HCFA proposes to exempt labs if they are in states with requirements that meet or exceed CLIA. *(Proposed rule to be published March, 1996.)*

- Use proficiency testing failures for education and as an outcome indicator in laboratory quality. Sanctions would be imposed only in cases of "immediate jeopardy" or when the lab has refused to correct the problem. *(Proposed rule to be published March, 1996.)*

A spokesperson from the American Clinical Laboratory Association said the HCFA proposals are a positive first step, but predicted plenty of discussion with HCFA, physicians and others before further changes are made in CLIA. **IM**

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For more information on any seminar, call Sherry Johnson at the IMS, 515/223-1401 or 800/728-5398.

MIDWEST MEDICAL INSURANCE COMPANY FOCUS ON RISK MANAGEMENT

Failure to diagnose breast cancer

Delay in diagnosing breast cancer accounts for more medical malpractice claims than any other single allegation made against physicians. A 1995 study by the Physician Insurers Association of America indicates that problems with diagnosis of breast cancer are a major source of malpractice loss for physicians who treat women.

According to the study, several factors contribute to delays in diagnosis: 1) failure of the physician to be impressed by physical findings or patient complaints; 2) lack of timely follow-up; 3) negative or equivocal mammogram report; and 4) misread mammogram.

Consider the following risk management recommendations:

- Do not exclude the possibility of breast cancer on the basis of a negative or equivocal mammogram alone.
- Do not exclude the possibility of breast cancer because you are unimpressed by the physical findings or patient complaints.
- Do not file a mammogram report in the patient's chart unless it has been reviewed with the exam findings and initialed by the physician.
- Follow up with patients when their condition warrants it. Systems should be in place to remind physicians to follow up.

For further information, contact Lori Atkinson, MMIC risk management coordinator, MMIC West Des Moines office, PO Box 65790, West Des Moines, 50265, 800/798-9870 or 515/223-1482

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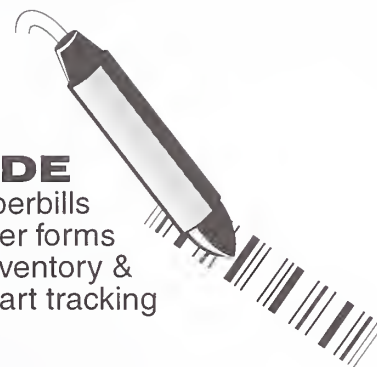
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Newsmakers

Medical supervision of student athletes

Dear Editor:

I thought your readers might be interested in and may benefit from a study regarding medical supervision of Iowa high school student athletes which was funded by the UI College of Medicine and endorsed by the Iowa High School Athletic Directors Association and the IMS Committee on Sports Medicine.

Questionnaires were sent to 426 Iowa schools; 403 were returned for a response rate of 94.5%. Results showed medical supervisors were in attendance at 78% of sporting events with high injury rates. Designated team physicians were reported at 41% of schools, with family physicians predominately at class 3A to A and family physicians and orthopedic surgeons at class 4A. Approximately one-third of high schools have athletic trainers. Health evaluation reports for student athletes were reported at 85% of schools and parental consent for treatment at 87%. Thirty-three percent have written plans for transportation of injured athletes and 64% have a driver and vehicle designated for emergency transportation. Training for CPR was reported for 68% of coaches. The majority of athletic directors indicated staff would benefit from education on management of the down athlete, rehabilitation programs, guidelines on returning to competition and head injuries.—*Daniel Fick, MD, Iowa City*

Awards, appointments, etc.

Dr. Bruce Gantz, Iowa City, has been appointed head of the Department of Otolaryngology at the UI College of Medicine. Dr. Gantz has served in the position on an interim basis for two years. **Dr. Joseph Veverka**, Prairie City, was recently honored by Iowa Lutheran

Hospital with an open house reception. Dr. Veverka was cited for his "many contributions to the medical staff and for the commitment you have demonstrated and the achievements you have made during your 30-year tenure at Iowa Lutheran Hospital." **Dr. Wilbur Smith**, UI College of Medicine professor and interim head of the Department of Radiology, has been elected to a one-year term as president of the Association of University Radiologists and a three-year term as treasurer of the Society for Pediatric Radiology. **Dr. Edwin Stone**, assistant professor in the UI College of Medicine, Department of Ophthalmology, received a 1995 recognition award for outstanding contributions to visual research from Alcon Research Institute. **Dr. Ken Crawford** has begun practice in the Paullina Family Medicine Clinic, Sutherland Family Medicine Clinic and Ohme Medical Center in Primghar. **Dr. Curtis Reynolds**, Cedar Rapids, has been named director of Primary Care Services at Mercy Medical Center. Dr. Reynolds previously served as director of the Cedar Rapids Medical Education Program and the Family Practice Residency Program. **Dr. Gordon Baustian** has succeeded Dr. Reynolds as director of both programs. **Dr. Tony Myers** has been named assistant director of the Medical Education Program. **Dr. Andrew Patterson**, Cedar Rapids, is now physician director of Mercy Care North. Dr. Patterson succeeds **Dr. G.L. Schmitt**.

Deceased members

Robert Barton, MD, 84, life member, dermatology, St. Louis, Missouri, died May 2

John Downing, MD, 79, life member, pediatrics, Marion, died May 6

W.D. Haufe, MD, 76, life member, internal medicine, Bloomfield, died May 6

Russell Cox, MD, 75, radiology, Spirit Lake, died April 26

Kathleen Smith, MD, 44, general surgery, Des Moines, died June 4

Ralph Shepherd, MD, 73, anesthesiology, Des Moines, died June 3 **IM**

AT A GLANCE

A new partnership has been formed between the Cedar Rapids Physician-Hospital Organization (PHO) and Heritage National Healthplan, a subsidiary of John Deere Health Plan. The PHO and Heritage will introduce a new managed care health insurance plan to eastern Iowa.

Dr. Kelly Ross, St. Ansgar, 1994 Iowa Family Doctor of the Year, is one of 10 finalists for the national Family Doctor of the Year award sponsored by the American Academy of Family Practice.

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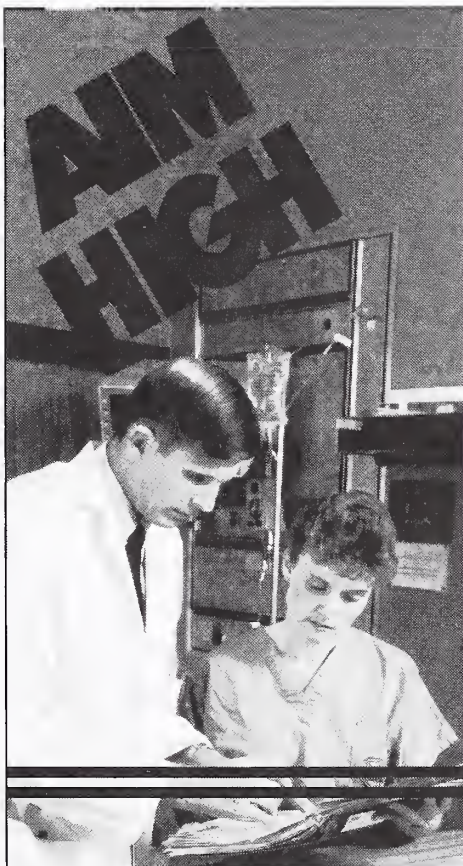
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Managed care in Iowa

A difficult TRANSITION

On March 1, Medco Behavioral Care began managing mental health services for Iowa's Title 19 population. The state says Medco can improve access and save money, but many providers and other patient advocates have grave concerns about Iowa's first major experience with managed care.

When Iowa psychiatrists gather these days, there's something interesting to talk about.

On March 1, Medco Behavioral Care (MBC), a New Jersey managed care company, took over management of mental health care for Iowa's Medicaid population. The project is groundbreaking on two fronts: it is Iowa's first major foray into managed care and Iowa is only the second state in the nation to turn all of its Medicaid mental health services over to a managed care company.

Stating it mildly, Iowa psychiatrists are concerned over some of Medco's policies and their possible effect on patients. However, officials of the Department of Human Services — which awarded the managed care contract to Medco — say that steps are being taken to address these concerns.

Brice Oakley, CEO of Medco of Iowa, believes some of the problems experienced by providers are the result of the transition to managed care. He says Medco is trying to do a better job at communicating with providers and remains confident that managed mental health care can be successful in Iowa.

Survey results disturbing

Dr. Jerry Lewis, a Newton psychiatrist and president-elect of the Iowa Psychiatric Society (IPS), says Medco's relationship with Iowa physicians began "with an

element of mistrust" when the company sent out contracts containing a 'hold harmless' clause. (Hold harmless clauses shift liability from the managed care company to physicians. Lawyers consistently advise physicians against signing contracts containing such a clause. After negotiations, the clause was removed.)

In a recent survey conducted by the IPS, respondents expressed a litany of other complaints about Medco policies and their effect on patients.

Universal concerns include Medco's denial of hospitalizations for seriously-ill patients who have no alternatives, inconsistency among reviewers, no notification of changes in procedures, slow payment of claims and too much time spent on paperwork and in dealing with denials.

Some respondents recounted specific anecdotes involving children who were denied hospitalization even though they demonstrated "serious assaultive behavior" or suicidal tendencies.

Several physicians complained that they spend 45 to 60 minutes on the phone every day or every other day talking to reviewers when they hospitalize a Medicaid patient.

Some psychiatrists said they may not sign a Medco contract; others — including several young physicians — said they are

"You need an option for these children before you take them out of the system."

CHRISTINE McMAHON
Ms. McMahon is director of communications for the Iowa Medical Society and managing editor of Iowa Medicine.

reconsidering whether or not to continue caring for Title 19 patients.

"I realize the state needed to save money, but this is too much control," comments Dr. Lewis. "They're taking money out of the system and making it very difficult to get care for patients."

According to Dr. Lewis and others, one of the major problems is Medco's contention that some kids now receiving services through Medicaid actually belong in the juvenile justice system.

"Rightly or wrongly, kids who have a diagnosis of conduct disorder have been handled in inpatient settings. Medco says these kids aren't psychiatrically ill. Whether or not this is true, you need an option for these children before you take them out of the system. Now, most are just going back to their families," Dr. Lewis explains.

Medco meets with UI staff

Physicians with the University of Iowa Department of Psychiatry have held several meetings with Medco representatives regarding "a number of concerns we're trying to work out", according to Bob Robinson, MD, professor and department head.

Dr. Robinson says one area of concern is authorization for hospital admissions for patients who are not acutely dangerous but have long-standing psycho-social problems. UI physicians have also had difficulty dealing with approval for continued stays in the hospital.

"The kinds of problems we see here just can't be resolved in 24 hours," he explains. "We're working with Medco trying to come up with treatment plans so these patients are approved ahead of time and we don't have to spend time on the telephone every day."

Dr. Robinson says that the issue of placing patients into lesser levels of care requires more study.

"First, you have to study whether it's appropriate to care for some of these patients at a lower level. Then you have to study whether the lower level of care is even available. Also, if someone isn't responding to local care, they may have to come here on a scheduled basis. The problem is, Medco abhors scheduled admissions."

He also points out that when patients come from far away, options such as partial

hospitalization can only work if the patient has somewhere to go at night. (Partial hospitalization is part of a program to reduce length of stays which began at the UI about a year and a half ago.)

A follow-up meeting is planned at the UI, at which time Medco is supposed to provide new criteria for continued hospital stays, possibly in a check-off format.

"Medco staff must appreciate the nature of problems unique to a rural state such as Iowa," he concludes. "We are hopeful these difficulties can be worked out."

Legal advocates are concerned, too

Tom Krause of Legal Services of Iowa says implementation of the Medco contract was "rushed" and that Medco's criteria for hospital admission are unacceptable.

"When the state receives federal Medicaid dollars, it means they must provide necessary care. The state contract with Medco gives Medco the sole power to determine medical necessity. This is not acceptable."

There is also a problem with the appeals process, says Krause.

continued

"The kinds of problems we see here just can't be resolved in 24 hours."

BE ASSERTIVE, ADVISES PSYCHIATRIC OFFICE RN

Having someone like Brenda Downey, RN in your office may be a key factor in your success with managed care.

"Sure, we get frustrated at times, but managed care is here to stay. This population is the most problematic of mental patients — they are extremely difficult to manage," says Ms. Downey, the case manager in the office of Des Moines psychiatrist Randall Kavalier, DO. "Our approach is to look for any possible opportunity to accommodate our patients."

Ms. Downey believes Medco is sincerely trying to correct problems. She also believes that since managed care is new here, some Iowa physicians are unaccustomed to the case management required for dealing effectively with Medco and don't know the right way to talk to the company's reviewers.

"Don't describe the situation — give your professional judgment based on the facts of the situation. You're trained and licensed to give a professional opinion, give it without hesitation. Be sure you're giving the correct information to the reviewer and using the appropriate verbiage."

Ms. Downey sometimes asks the reviewer to send a field representative to Dr. Kavalier's office and says these representatives have been "very helpful" in cases where she and the telephone reviewer couldn't agree on the need for hospitalization. She is also not afraid to request that a physician reviewer come to the phone and discuss a case with her.

"You're the professional, you're the patient advocate. Be confident and assertive in the decisions you've made," she advises.

"We have one child who has been in 18 different placements in the past year. These aren't Medco problems."

"When you kick someone out of the hospital, you effectively remove the appeals process. So what if someone comes along later and says the denial was wrong?"

Legal Services of Iowa, with the support of the Youth Law Center, is monitoring Medco's operation in Iowa and is considering filing a lawsuit on behalf of Medicaid recipients.

The Child Protection Council, a multi-disciplinary group of child advocates, has sent a letter to Governor Branstad asking that the Medco contract be reconsidered "in light of the multitude of bad experiences reported by juvenile judges, county attorneys and health care providers". The letter expresses particular concern over Medco's "unacceptable" hospitalization policy for children who express suicidal thoughts.

The Iowa Code says if children are a danger to themselves or others, judges can place them in a hospital, with Medicaid picking up the tab.

However, Medco has reportedly denied payment for some of these hospitalizations and juvenile judges met recently with Medco officials to discuss the problem. Bert Aunan, chief juvenile court officer in the Fifth District, said he is satisfied that Medco is rethinking the issue.

"Some of these kids need hospitalization because that's the only way to get a true assessment," he explains. "Also, Medco has said if there is a safety issue, the child should stay in the higher level of care."

Aunan said he and his colleagues are concerned that Medco's criteria are more appropriate for adults than for children. They are also apprehensive about the lack of options for those denied hospitalization.

"We recognize Medco is going to have shorter lengths of stay. Our task now is to figure out how to provide and fund lower

levels of service."

According to Aunan, facilities such as group homes are not a feasible alternative to hospitalization because they already operate at near capacity. If the juvenile justice system is going to be expected to step into the gap, additional funding will be required, he added.

"I'll continue to advocate for kids," he stresses. "I believe Medco is taking a look at the process and is willing to make changes."

Problems inherent in the system

Des Moines psychiatrist Dr. Randall Kavalier says it's not surprising that everyone in the system is struggling to make the transition to managed care. A large part of the problem could be that many psychiatrists practice in areas where there is no "safe back door" or lower level of care available for children who stay only a short time in the hospital or are denied for hospitalization.

"I benefit from Mercy system because our focus already is on shorter stays with a continuum of care," he explains. "I suppose my style of practice is more consistent with managed care."

He confirms the "reluctance of the courts to take young people and incarcerate them" if they have not really committed a crime — for example, a 10-year-old who brings a gun to school.

"That child needs evaluation in an office like mine. Some things just can't be determined by a simple checklist. Maybe he brought the gun to school because he was frightened."

However, both Dr. Kavalier and his case manager Brenda Downey, RN believe many of the problems in the system existed long before Medco came to town.

"My biggest concern is how the whole system works. The Department of Human Services is seriously overburdened," contends Ms. Downey. "We have one child who's been in 18 different placements in the past year. Today, I applied for emergency foster care for

THEY NEED TO LET THE PSYCHIATRIST DECIDE THE TYPE OF TREATMENT PT. NEEDS. NOT ALWAYS 2ND GUESS HIS/HER DECISION. IF ANY OF THE PSYCHIATRIST MISJUDGING THE TYPE OF PT. NEEDS. THEN TO USE THIS KIND OF IMPROPER

Providers are upset, as demonstrated by this typical comment from a recent Iowa Psychiatric Society survey.

a 4-year-old who tried to push his brother out of a window and they told me it's a six-week wait. These aren't Medco problems."

Bill Dodds, managed care specialist with the Department of Human Services Division of Mental Health, says prior to Medco, Iowa's Medicaid program had "unfettered fee-for-service" with no central management of resources and little utilization management of payment for mental health services.

"The goal of managed mental health care was to reorganize the system to improve access to services and contain costs," he explains. "Services needed to be available more uniformly, especially in rural Iowa."

He said another goal is to "empower" Medicaid recipients to have more control over their lives. The DHS and Medco have planned six outreach meetings for people with mental illness to give them information on how to access the system and negotiate directly with Medco.

Problems are being worked on

Dodds says there are legitimate concerns with Medco policies but that he is "unaware of any that aren't being worked on".

Dodds acknowledges there are problems with the inter-relationship of funding and services for Medicaid and the juvenile justice system which existed before the Medco contract, but says these problems are not being ignored.

"Medco has been meeting with staff from the DHS and juvenile services on management of 25-50 difficult cases. This gives us a chance to analyze what services will be needed and manage the cases better."

Some providers have reported unpaid Medco claims which are four to five months old; Dodds says Medco probably underestimated the level of claims they would have to pay but is working to solve the problem.

Also, DHS is working toward making available "safety net services" as alter-natives to hospitalization. These services will include 24-hour crisis care, mobile crisis services, respite services and improvements in the "supported living" services which help spot developing problems.

"This has been an ambitious project," Dodds comments. "It's fair to say Medco is doing a good job of what they have experience doing."

Resolving issues is 'multi-year process'

Medco's Oakley says successful implementation of the managed mental health contract could be a multi-year process and that there have been "significant difficulties" in some areas.

"It's very clear that we (Medco) needed more experienced provider relations staff. We learned that 'early and often' is the rule for provider education and networking."

He says Medco is now "fleshing out" its criteria — criteria which were reviewed by "national experts" but not shown to Iowa providers before implementation.

The criteria were designed on a 'medical necessity model' but are now being expanded to take 'service necessity' into consideration.


"We think the expanded criteria will be more useful. This is Phase II — further development of the lesser levels of care," Oakley explains. "We understand that the mental health population sometimes has needs that are non-medical."

Oakley says statistics show Iowa having the fifth to eighth highest in-patient rate for Medicaid recipients.

"We need to utilize less intensive levels of service through better communication between physicians and reviewers," he explains. Medco's goal, he continues, is to move provider-reviewer encounters past the issuance of denials to actual discussions of all options available for the patient.

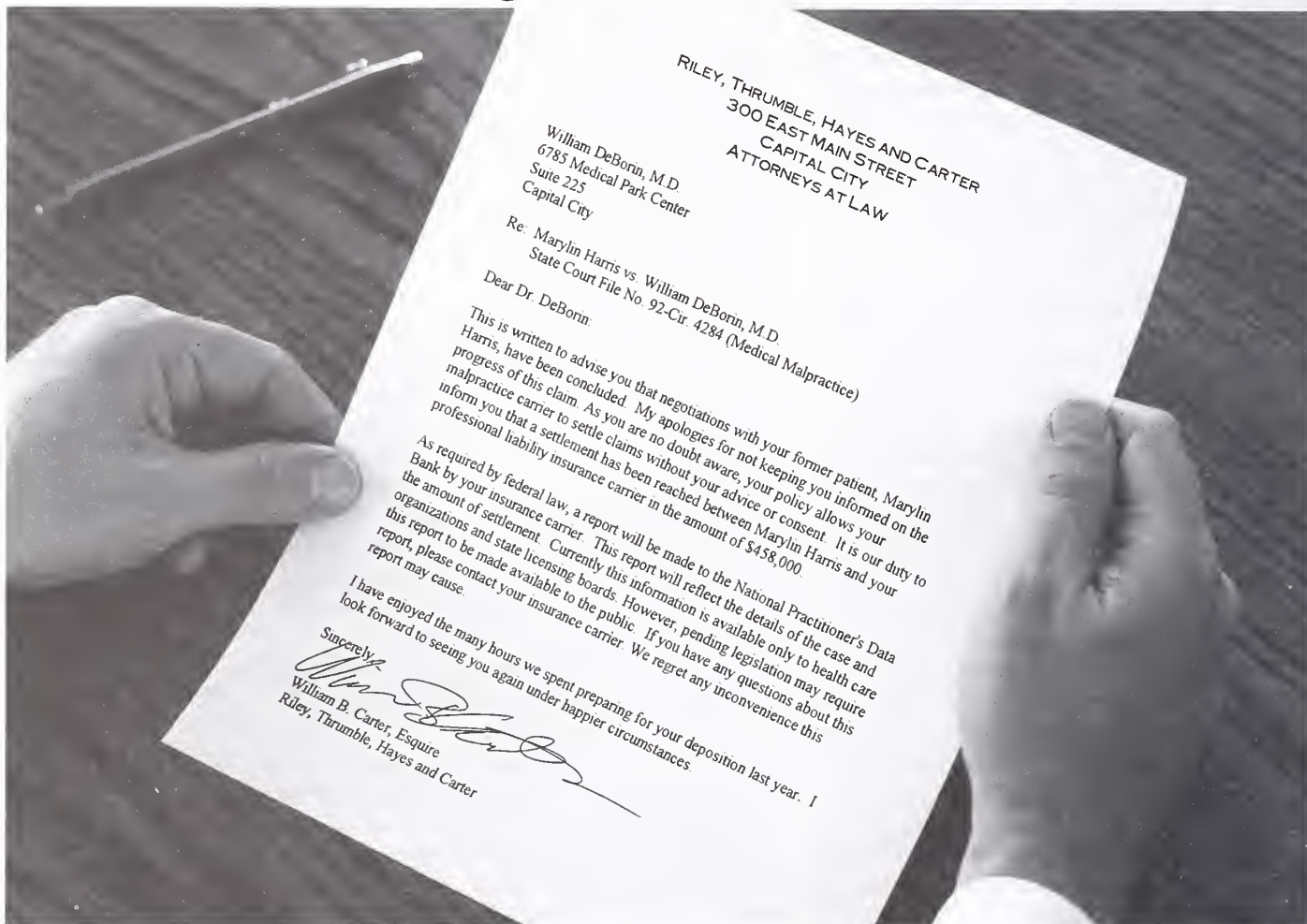
Oakley said staffing in the quality management area has been shored up and that Medco plans to send a newsletter to providers under contract regarding changes in policies and procedures. The company is also close to implementation of a pilot project for electronic claims.

Oakley says the state is going to a system "where only certain providers have access to the Medicaid population" but that there is no firm deadline for this to take place. He said he has no current information on how many providers have signed Medco contracts.

"We may have to contract for services in areas of the state where there are gaps," he comments. 

"It's very clear that we needed more experienced provider relations staff."

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The Journal

of the Iowa Medical Society

Metastasis of adenocarcinoma of breast to gluteus medius

● SUBHASH SAILAI, MD; DARCY LEIGH, DO

Breast carcinoma is the most common major cancer in females in the U.S. It is the second leading cause of deaths due to cancer in women; it accounts for 19% of all cancer-related deaths in women, second only to lung cancer.¹ As of 1990, it was estimated that one in every 10 American women would develop breast cancer.² The incidence has continued to increase and was estimated to be one in every 9 American women or 22.4 cases per 100,000 in 1992.^{1,3} Detection of early disease states and improved treatment modalities have increased survival rates such that mortality rates have remained relatively stable even though the incidence has risen.⁴

Controversy remains as to whether breast cancer is a systemic disease at the time of diagnosis or if it is a stepwise progression of metastasis.¹ However, the number of axillary lymph nodes involved continues to be the largest prognostic factor. Metastatic cells are shed into the venous circulation due to neovascularized communications or via lymphatic-venous communications. Ninety-five percent of the deaths in patients with uncontrolled breast cancer are those with distant metastasis. The most common sites of dissemination include bone, lung, pleura, soft tissues and liver, respectively. In 60% of patients who develop metastasis, it occurs during the first 24 months after mastectomy and is the most common cause of death between five and 10 years post-mastectomy¹.

The following is an unusual case report of a patient with metastatic adenocarcinoma of the breast who presented with further dissemination to the gluteus medius muscle.

Case presentation

A 64-year-old female presented to our clin-

ic for evaluation of sudden onset of severe pain originating in her right buttock and radiating to her right hip and lower extremity. The patient's past medical history was significant for adenocarcinoma of the breast, specifically infiltrating ductal carcinoma involving a single lymph node. This was initially diagnosed and treated with lumpectomy and radiation in 1990. Subsequent recurrence to the chest wall, axilla and pleura was treated unsuccessfully with hormonal agents (tamoxifen and megestrol), followed by a combination of cyclophosphamide, adriamycin and 5FU, and a course of mitomycin and velban, then most recently with taxol three weeks prior to the onset of buttock pain.

Further past medical history includes heavy alcohol abuse, chronic obstructive pulmonary disease, polypectomy of an adenomatous colonic polyp, left ovarian cyst with oophorectomy, ectopic pregnancy with right oophorectomy and salpingectomy and hemorrhoidectomy. Initial physical examination revealed no erythema, edema or cutaneous changes of the right buttock and hip, as well as normal range of motion of the hip joint. X-rays of the right hip and pelvis did not reveal any evidence of osteoblastic or osteoclastic activity. Subsequently, an isotopic bone scan was performed and also showed no evidence of bony metastatic disease. Laboratory studies revealed WBC 10,300, RBC 3.74 $\times 10^6$, HGB 10.6 g/dl, HCT 33.3%, MCV 89 fl, MCH 28.3 pg, RDW 16.4%, PLT 340,000 and ESR 30 mm/hr.

During the next three days the patient's pain intensified and physical examination revealed marked pitting edema of the right buttock, hip and leg. These areas were also extremely tender upon palpation. Range of motion of the hip joint was within normal

The IMS Education Fund has designated this article as the Henry Albert Scientific Presentation Award for September 1995.

SUBHASH SAILAI, MD

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DARCY LEIGH, DO

Dr. Leigh is a family practice resident at Methodist Hospital, University of Illinois.

Metastasis of adenocarcinoma of breast to gluteus medius

continued

limits except for restriction in external rotation. Computed tomography of the pelvis indicated diffuse enlargement and increased vascularity of the gluteus medius muscle that was related either to inflammatory or neoplastic origin. Fine needle aspiration of the fluctuant buttock was obtained and sent for both cytology and culture and sensitivity. Ultrasound at this time did not reveal any abscesses, so the patient was placed on anti-inflammatory agents and dilaudid 2 mg every four hours as needed for pain while awaiting the aspiration results.

Two days later the patient's pain was no longer being controlled by oral medications and she was admitted to the hospital for intravenous patient controlled administration of Nubain (nalbuphine hydrochloride). Heparin 5,000 U SQ every 12 hours and ampicillin 1.5 gm IVPB every six hours were also begun. Laboratory studies revealed WBC 13,900, RBC 3.82×10^6 , HGB 11.1 g/dl, HCT 34.0%, RDW 16.6%, PLT 351,000, ESR 33 mm/hr, sodium 145 meq/L, potassium 3.7 meq/L, BUN 7 mg/dl, creatinine 0.6 mg/dl, chloride 105 meq/L, CO₂ 31 meq/L, glucose 94 mg/dl, calcium 8.9 mg/dl, alkaline phosphatase 86 U/L, LDH 211 U/L, uric acid 2.3 mg/dl, total protein 5.8 g/dl, and albumin 3.6 g/dl. The pathology report of the fine needle aspiration returned strongly suspicious for adenocarcinoma and the culture was negative for bacteria.

Treatment

Computed tomography guided needle aspiration of the gluteus medius muscle was performed, which revealed a poorly undifferentiated carcinoma with a histology consistent with adenocarcinoma. A palliative radiation course of 3,750 cGy in 15 treatments to the right hemi-pelvis and gluteal muscle was begun. The patient remained hospitalized for pain control during the first 11 radiation treatments, during which time she was weaned from intravenous to oral medications as her symptoms began to subside. The patient was maintained at a relatively pain-free level on oral medications (MS Contin [morphine sulfate control release] and Naprosyn) and finished the course of radiation at home.

Discussion

Infiltrating ductal carcinoma accounts for the majority of breast cancers (75%).⁶ They commonly invade the axillary lymph nodes and have the most ominous prognosis. They most frequently metastasize to bone or intraparenchymal sites such as the lung, liver or brain, whereas metastasis to the meninges, serosal surfaces and other atypical sites is more common with lobular carcinoma.^{5,6} Generally, the prognosis is directly proportional to the number of lymph nodes involved. In our patient's case, only one axillary lymph node was involved, but her disease progressed rapidly to multiple sites. The most unusual site was the ipsilateral gluteus medius muscle, which to the best of our knowledge has not previously been reported.

References

References noted in this article are available from the authors or the editors of *Iowa Medicine*. IM

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Drive-thru delivery

A cartoon in the *Des Moines Register* (July 18, 1995) depicts a hospital with a large sign over the door "General Insurance Co. and Hospital". The word "hospital" is in smaller sized letters. The cartoon further has a sign directing patients to a "drive-thru" delivery area. A pompous appearing man complete with brief case is emerging saying "Since we make the decisions we felt we should have top billing." This cartoon refers to a recent decision by insurance companies that birthing should entail only a 24-hour confinement period.

Over the past decades there has been an insidious trend toward decreasing the time allocated for maternity stays in hospitals. A number of years ago, it was 10 days with the first five days requiring the mother to remain at bed rest; then the stay was decreased to five days with the mother urged to be more active. Now, it's "in, up and out."

The increasing frequency of out-patient surgical procedures has certainly been conducive to shorter maternity stays. With

births, however, we have two patients. The new mother has a helpless infant to care for. Can the father obtain sick leave? Can a grandmother leave her home far away to help her daughter? Are there neighbors who can help as in years past . . . or are all of them employed full-time outside their homes? What's a mother to do? Some would say this is a social problem and has nothing to do

with health care delivery. How crass!

So far, little has been said about the newborn infant. Have far-sighted pediatricians been consulted about the short hospital stays? If jaundice ensues, imagine how difficult it will be for the mother to go to the physicians' office for evaluation of the infant; and most likely elsewhere if laboratory determinations are indicated. If the family is involved with an HMO, the "Mickey Mouse" routine of arranging consultations might be a factor.

This all becomes very complicated. Our medical world has changed very drastically. Health care delivery has become the domain of persons other than those involved in the time-honored physician-patient relationship.

**We physicians
must be
cognizant of
the traps that
are being laid
before us.**

The battle cry is to cut medical costs but it appears that eventually there are no cuts. Profits will go to the stockholders and the administrators of health management rather than to the providers and to reduce health care costs.

We must educate our patients of all the hazards facing the delivery of health care. We physicians must be cognizant of the traps that are being laid before us. Our patients must be considered first and foremost. After all, in the long run, it's their health and their money. **IM**



MARION ALBERTS, MD



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Remembering

Growing older often provides occasions to recall and reflect, as long as we haven't yet lost those abilities. So it was with me recently when 35 of my medical school classmates gathered for a reunion. Those of us who chose to attend and were physically and fiscally able to do so looked pretty good, I thought.

I was impressed with how many of the class of 1955 had already entered retirement, and I don't mean just "slowing down". I've a hunch most of us at our graduation would have thought it either outrageous or ridiculous if someone had predicted the reality that has occurred. I won't pause now to muster the diverse factors that probably led to the individual decisions; it might make an interesting exercise for later, though. Fourteen of the 107 of us are known to have died. That's probably a pretty good record, actuarially speaking, but reading the list of the dead certainly dampens the general atmosphere of partying and celebration.

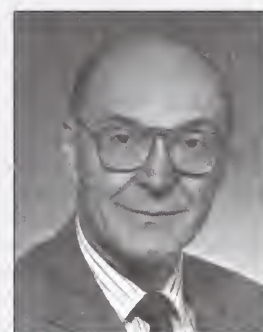
The University of Iowa Alumni Association provided a display of major news events of 1955. They didn't say whether the point was to amuse us, or force us to face our mortality. Boy, was that list a shock: U.S. Begins Aid to Indochina; Nikita Krushchev Becomes Party Secretary; Supreme Court Orders End to School Segregation; Military Ousts Juan Peron; Ike Suffers Heart Attack; George Meany to Lead Merged AFL and CIO;

Dow Jones Average Ranged Between 391 and 488; James Dean Scores Big in "Rebel Without a Cause"; Lawrence Welk Show and Captain Kangaroo Have TV Premieres; top box-office stars include James Stewart, Grace Kelly, John Wayne, Humphrey Bogart, June Allyson and Clark Gable; hit songs were "The Ballad of Davy Crockett" and "Love is a Many-Splendored Thing"; "Cat on a Hot Tin Roof" wins Pulitzer Prize; Marian Anderson breaks color barrier at the Met; Disneyland opens in Anaheim; Richard Nixon proclaims "Sincerity is the quality that comes through on television." New terms appeared: automated, junk mail, blast off, third world.

On the medical scene, infant mortality in the U.S. was then 26.0/1000 (now about 8.0) and there were 214,000 U.S. physicians (now more than 600,000). "The Pill" came into use, prednisone was introduced, chloramphenicol was found to cause some hematological trouble and Thorazine and Reserpine were found effective for severe mental illness.

**Not everything
that seemed
to be progress
then has
maintained its
luster.**

Not everything that seemed to be progress then has maintained its luster—all known silver linings have their dark clouds. If I attend my 50th anniversary reunion, I'm sure I'll be amazed, impressed and both delighted and saddened at what will have transpired between now and then. I guess I'd like to hang around and find out. **IM**



RICHARD CAPLAN, MD

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Eseape from the ordinary!—General surgeon needed to work in our thriving rural family practice. Candidate should have skills in C-section, gyne and laparoscopic surgery. Eight weeks vacation/CME. Consultants available. Only group in county with 3 referral centers one hour away. Uniquely situated on I-94 half way between Madison and Twin Cities. Small town pride, excellent 51-bed hospital, great schools and recreation including all water sports, hunting, fishing, cross-country and downhill skiing Cohesive group of caring physicians! Contact or send CV to Gary K. Petersen, Krohn Clinic, Ltd. 610 W. Adams St., Black River Falls, Wisconsin 54615; 715/284-4311.

Keosauqua

Van Buren County Hospital

Seeking quality primary care trained or emergency medicine physician to practice at VBCH.

- 2400 annual volume
- 36-hour weekend shifts (10 am Sat—10 pm Sun)
- Regular part-time and moonlighting opportunities
- Paid St. Paul malpractice
- Easy travel access

Send CV or contact

Melissa J. Milliken, CMSC

ACUTE CARE, INC.

PO Box 515, Ankeny, IA 50021
800/729-7813 or 515/964-2772
Fax 515/964-2777

Charles City

Floyd County Memorial Hospital

Seeking quality primary care trained or emergency medicine physician to practice at FCMC.

- Regular part-time or moonlighting opportunities
- Weeknights, 12-hour shifts
- Low to moderate volume
- Highly competitive compensation
- Paid St. Paul malpractice

**Send CV or contact
Melissa J. Milliken, CMSC**

ACUTE CARE, INC.

PO Box 515, Ankeny, IA 50021
800/729-7813 or 515/964-2772
Fax 515/964-2777

Knoxville VA Medical Center—is currently seeking applications for the position of Chief, Medical Service. Candidates must be board certified in internal medicine and have experience in the VA system. Applicants must have a demonstrated commitment to patient care as well as supervisory and leadership experience and capabilities. The focus on a primary care model will provide a unique opportunity for the selectee to develop and implement a marketing strategy to broaden the customer base, while providing the highest quality of health care to the veterans seeking treatment at KVAMC. As the Medical Center has converted to electronic medical records, computer skills are desirable. (Training is also available on station.) Interested applicants who meet these qualifications and are interested in the challenges and rewards this position could provide should contact David K. Kentsmith, M.D., Chief of Staff at 515/828-5003. EEO.

Iowa & Nebraska

Acute Care Anesthesia Services, LC

*Recruiting MD/DO
Anesthesiologists & CRNAs*

- Professionally rewarding, equitable anesthesia practices
- Full-time and part-time
- Incentive-based compensation and benefits—including St. Paul medical professional liability insurance

**Send CV or contact
Melissa J. Milliken, CMSC
ACUTE CARE, INC.**

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Fax 515/964-2777

Family Practitioner—McFarland Clinic is actively recruiting a BE/BC family practice physician to assume the responsibilities of an established family medicine practice in central Iowa. Practitioner has support of over 80 medical and surgical sub-specialty physicians in same multispecialty group. Full privileges for a residency-trained family physician at Mary Greeley Medical Center, a 200-bed hospital in Ames, Iowa. Night call on a rotating basis at the Emergency Room at MGMC. McFarland Clinic offers distinct advantages for the practicing physician in providing excellent compensation and benefits, practice management services and a generous retirement program, all in an environment which emphasizes physician cooperation and teamwork. For additional information, call or submit CV to Karen Andersen, 515/239-4535, McFarland Clinic, P.C., 1215 Duff Avenue, Ames, Iowa 50010.



Rural lakeside community provides unique setting for self-styled family practice. Employment with clinic foundation owned by county hospital means no buy-ins, 1:9 call coverage with weekend ER relief coverage, full employment contract with guarantee and excellent benefit package. You determine what patients to hand off in an outpatient hospital based referral system of 25 specialists. A+ schools, A+ recreations and A+ amenities. Send CV or call Darrell Pritchard, Administrator, Buena Vista Clinic, Box 742, Storm Lake, Iowa 50588; collect 712/732-5012; fax 712/732-2538.

Family Medicine—Loving your job is no longer a myth! Opportunities are now available for family physicians who believe that professional satisfaction and personal happiness are equally important. A prominent 300+ physician-owned group based in southwest Wisconsin has practice opportunities available at established clinics in Iowa and Wisconsin. Exceptional call coverage results in more time to savor the breathtaking river communities, rolling hills and woodlands. If outdoor activities, cultural amenities and a superior practice environment are important to you, please call Susan Pierce at 800/243-4353.

Council Bluffs

Ambulatory Care Clinic

Seeking quality physician to practice either part, full-time or moonlighting during residency.

- Primary care, urgent care, occupational and sports medicine
- Weekday, weeknight and weekend shifts
- Paid St. Paul malpractice
- Excellent benefit/bonus packages

**Send CV or contact
Melissa J. Milliken, CMSC**

ACUTE CARE, INC.

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800/729-7813 or 515/964-2772
Fax 515/964-2777

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800/880-2028, Fax 812/331-0659
Job #C133MJ

(Continued next page)

Advertising Rates and Data

Regular classified advertising sells for \$2.00 per line with a \$30 minimum per insertion. For members of the Iowa Medical Society the rate is \$20 per insertion. Display classified advertising sells for \$25 per column inch, per month. Sizes range from 1 column by 2 inches to 1 column by 6 inches. A variety of type sizes, borders, reverses or screens can be included in the ad. Blind box numbers are available upon request at no additional charge. Copy deadline is the 1st of the month preceding publication. Send or fax copy to Iowa Medicine, 1001 Grand Avenue, West Des Moines, Iowa 50265-3599, fax 515/223-8420.

Family Physician—Family Medical Center is actively recruiting a BE/BC family physician to join 8 other family physicians and one general surgeon. Practice opportunity provides 1:9 call schedule, with full-time hospital ER coverage. Contract provides for attractive salary and excellent benefits. Send CV to Linda Cohrt, Office Manager, 1225 C. Avenue East, Oskaloosa, Iowa 52577 or fax 515/672-2258.

Family Practice Physician—Rare opportunity for a BE/BC family practice physician to join an established, progressive 8-physician practice in Marshalltown, Iowa, a thriving family oriented community 40 miles northeast of Des Moines. We have a beautiful new facility, a qualified staff and enjoy a supportive relationship with our 176-bed local hospital. Our philosophy is to provide personal, quality care to each of our patients, while maintaining our productivity, profitability and efficiency. This position offers an excellent benefit package, a voice in decision-making, 1 in 8 call and a very competitive salary/dividend package. For more information call or write to Michael Miriovsky, MD or James Burke, MD, Center for Family Medicine, PLC, 312 E. Main Street, Marshalltown, Iowa 50158 or call 515/752-5469.

Director, Obstetrics and Gynecology—Broadlawns Medical Center, a 200+ bed county/community teaching hospital serving metropolitan Des Moines and Polk County, is seeking a well-rounded physician to direct the ob/gyn department. Activities will include supervising patient care teaching of family practice residents, a rotating ob/gyn resident and medical students in OB (500 births per year and growing). Department includes medical office clinical facilities, a Family Birthing Center with LDRP room accommodations; a Family Planning Program and mid-wife positions. Qualifications include an MD or DO degree, board certification or active candidacy of the American Board of Obstetrics and Gynecology, extensive practice experience and the ability to direct staff and programs to support the service and education goals of the facility. Clinical teaching experience is desirable. Post offer/pre-employment physical and drug screen required. This is a University of Iowa clinical appointment. Take the challenge and join our team! If interested contact D.J. Walter, MD, 1801 Hickman Road, Des Moines, Iowa 50314; 515/282-2203. Minorities and women encouraged to apply. Broadlawns is an Equal Opportunity/Affirmative Action Employer.

Family Practitioner • Internist

Want the best of BOTH worlds?

Live and work in a rural community—yet have easy access to the educational, cultural, shopping, and entertainment opportunities of the big city. Enjoy all the benefits that go with small-town living—good neighbors, safe schools, affordable housing, abundant recreational choices—and go to the city when *you* want!

St. Croix Falls, Wisconsin is located just over the scenic St. Croix River from Taylors Falls, Minnesota and within 45 minutes of the metropolitan Twin Cities. With 25,000 households within the clinic service area, River Valley Medical Center is the region's largest and most diversified practice group—13 family practitioners, 2 internists, 2 general surgeons, 2 orthopedic surgeons and a physician assistant. Clinic is attached to a 50-bed acute care hospital with a wide range of services.

Guaranteed first-year salary with second-year partnership and excellent fringes.



Send detailed CV to:
Cathy Kortas
River Valley Medical Center
208 S. Adams St.
St. Croix Falls, WI 54024

Orthopaedic Surgeon, Clinton, Iowa

For general orthopaedics. . . Join our 32-physician multispecialty group partnership with a newly expanded, modern 70,000 square feet office. Group established and thriving 29 years. Strong referral base and excellent industrial base and support. Compensation competitive. Positions also in Logansport, Indiana and Effingham, Illinois.

Dermatologists Wanted

6 immediate positions. Miami Beach and North Florida, Minnesota, Georgia, California and Texas. BE/BC required. Salary to \$200k and negotiable.

Ob/gyn & Plastic Surgeon Wanted

Open your own practice in our Miami Beach, Florida very successful multispecialty group. No fees, just split overhead expenses. BE/BC and Florida license required.

Fax or send CV or call Avionne Allen
Physician's Placement Management Group
1000 Blythwood Place, Suite C-199
Davenport, IA 52804
800/251-6937 or fax 800/289-9754

LeMars

Floyd Valley Hospital

Seeking quality primary care trained or emergency medicine physician to practice at FVH.

- 4300 average volume ER
- Medical director and staff positions
- Full-time, regular part-time and moonlighting opportunities
- Weeknight, 12-hour shifts and weekends
- Highly competitive salary
- Paid St. Paul malpractice

Send CV or contact
Melissa J. Milliken, CMSC

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Des Moines: 515-245-4688**

Professional Listing

Allergy

John A. Caffrey, MD, PC
1212 Pleasant, Suite 106
Des Moines 50309
515/243-0590
Allergy & Immunology

Allergy Institute, PC
A.Y. Al-Shash, MD
R.K. Agarwal, MD
1701 22nd Street, Suite 201
West Des Moines 50266
515/223-8622

Pediatric and Adult Allergy, PC
Veljko K. Zivkovich, MD
Robert A. Colman, MD
1212 Pleasant, Suite 110
Des Moines 50309
515/244-7229
Asthma, Allergy & Immunology

Dermatology

Robert J. Barry, MD
1030 Fifth Avenue, SE
Cedar Rapids 52403
319/366-7541
*Practice Limited to Disease,
Cancer and Surgery of Skin*

Fort Dodge Medical Center, PC
Carey A. Bligard, MD, FAAD
James D. Bunker, MD, FAAD
800 Kenyon Road
Fort Dodge 50501
515/574-6850

Electrodiagnosis

John Milner-Brage, MD
208 St. Francis Professional Building
Waterloo 50702
319/234-6446
*Electromyography & Nerve
Conduction Studies*
*Certified by American Board of
Electrodiagnostic Medicine*

Emergency Medicine

Acute Care, Inc.
P.O. Box 515
Ankeny 50021
515/964-2772 or 1-800/729-7813
*Comprehensive Emergency Medicine
Practice, Locum Tenens,
Doctor on Call*

Emergency Practice Associates
P.O. Box 1260
Waterloo 50704
1-800/458-5003
*Specialists in Emergency
Staffing & Emergency Department Services*

Family Practice

Acute Care, Inc.
P.O. Box 515
Ankeny 50021
515/964-2772 or 1-800/729-7813
*Locum Tenens
Doctor on Call*

Infectious Diseases

**Chest, Infectious Diseases & Critical Care
Associates, PC**
Daniel H. Gervieh, MD
Daniel J. Schroeder, MD
Ravi K. Vemuri, MD
Infectious Diseases
1601 NW 114th, Suite 347
Des Moines 50325-7072
24 Hours 515/224-1777

Infertility

Mid-Iowa Fertility, PC
Donald C. Young, DO
3408 Woodland Avenue, Suite 302
West Des Moines 50266
515/222-3060
*Reproductive Endocrinology/Infertility
IVF and GIFT Procedures
Donor Oocyte Program
Artificial Inseminations
Reproductive Surgery
Menopause Management*

Internal Medicine

Fort Dodge Medical Center, PC
Cardiology
Samir G. Artoul, MD, FICC
515/574-6840
Gastroenterology
Kenneth W. Adams, DO, AOBIM
General Internal Medicine
William C. Robb, MD
Richard H. Brandt, MD, ABIM
Grace Z. Ang, MD
800 Kenyon Road
Fort Dodge 50501
515/574-6820

Neurology

Iowa Medical Clinic Neurology
Andrew C. Peterson, MD
Laurence S. Krain, MD
600 7th Street SE
Cedar Rapids 52401
319/398-1721
*Neurology, EEG, EMG, Evoked Potentials
and Sleep Studies*

Fort Dodge Medical Center, PC
Jugal T. Raval, MD, MBBS
800 Kenyon Road
Fort Dodge 50501
515/574-6845

Neurosurgery

Iowa Medical Clinic
Neurosurgery
James R. Lamorgese, MD
Loren J. Mouw, MD
600 7th Street, SE
Cedar Rapids 52401
319/366-0481
Practice limited to Neurosurgery

Hosung Chung, MD
2710 St. Francis Drive, Suite 401
Waterloo 50702
319/232-8756; fax 319/232-5703
Practice limited to Neurosurgery

Neurosurgical Services LLP

Robert Hayne, MD

Thomas A. Carlstrom, MD

David J. Boarini, MD

1215 Pleasant, Suite 608

Des Moines 50309

515/241-5760

Robert C. Jones, MD

S. Randy Winston, MD

Douglas R. Koontz, MD

2600 Grand Avenue, Suite 210

Des Moines 50312

515/283-2217

Neurological Surgery

Chad D. Abernathy, MD

1953 1st Avenue SE

Cedar Rapids 52402

319/363-4622

Neurological Surgery

Obstetrics/Gynecology

Fort Dodge Medical Center, PC

Brian L. Welch, MD

800 Kenyon Road

Fort Dodge 50501

515/574-6870

Ophthalmology

Wolfe Clinic, PC

Russell H. Watt, MD

John M. Graether, MD

Gilbert W. Harris, MD

James A. Davison, MD

Norman F. Woodlief, MD

Eric W. Bligard, MD

David D. Saggau, MD

Steven C. Johnson, MD

Todd W. Gothard, MD

309 East Church

Marshalltown 50158

515/754-6200

Satellite Offices

Lakeview Medical Park

5000 University Avenue, Suite 300

West Des Moines 50266

515/223-8685

804 South Kenyon Road, Suite 100

Fort Dodge 50501

515/576-7777

Sartori Professional Building

516 South Division Street

Cedar Falls 50613

319/277-0103

214 - 13th Street Southeast

Cedar Rapids 52403

319/362-8032

Ophthalmic Associates, PC

Robert D. Whinery, MD

Stephen H. Wolken, MD

Robert B. Goffstein, MD

Lyse S. Strnad, MD

John F. Stamler, MD, PhD

540 E. Jefferson, Suite 201

Iowa City 52245

319/338-3623

North Iowa Eye Clinic, PC

Addison W. Brown, Jr., MD

Michael L. Long, MD

Bradley L. Isaak, MD

Randall S. Brenton, MD

James L. Dummett, MD

Mick E. Vanden Bosch, MD

3121 4th Street, S.W.

P.O. Box 1877

Mason City 50401

515/423-8861

Timothy F. Moran, Jr., MD

United Federal Building

700 4th Street, Suite 305

Sioux City 51101

712/252-4333

Satellite Clinics

Horn Memorial Hospital

700 E. 2nd Street

Ida Grove 51445

712/364-3311

Orange City Hospital

400 Central Avenue NW

Orange City 51041

712/737-2426

General Ophthalmology

Orthopaedics

Iowa Orthopaedic Center, PC

Marvin H. Dubansky, MD

Marshall Flapan, MD

Sinesio Misol, MD

Joshua D. Kimelman, DO

Timothy G. Kenney, MD

Lynn M. Lindaman, MD

Jeffrey M. Farber, MD

Kyle S. Galles, MD

Scott A. Meyer, MD

Cassim M. Igram, MD

Rodney E. Johnson, MD

Martin S. Rosenfeld, DO

Donna J. Bahls, MD

Jill R. Meilahn, DO

Jacqueline M. Stoken, DO

411 Laurel, Suite 3300

Des Moines 50314

515/247-8400

Orthopaedic Surgery

Fort Dodge Medical Center, PC

C. Mark Race, MD

800 Kenyon Road

Fort Dodge 50501

515/574-6880

Otolaryngology

Iowa ENT, PC

Thomas A. Eriksen, MD

Marshall C. Greiman, MD

Steven R. Herwig, DO

Thomas O. Paulson, MD

Mark K. Zlab, MD

1-800/248-4443

1215 Pleasant, Suite 408

Des Moines 50309

515/241-5780

1200 35th Street, Suite 200

West Des Moines 50266

515/225-7761

Satellite Clinics:

Pella, Perry, Newton, Indianola,

Oskaloosa, Guthrie Center, Knoxville

Wolfe Clinic, PC

Michael W. Hill, MD

Daniel J. Blum, MD

309 East Church

Marshalltown 50158

515/752-1566

Lakeview Medical Park

6000 University Avenue, Suite 310

West Des Moines 50266

515/224-9533

Sartori Professional Building

516 South Division Street

Cedar Falls 50613

319/277-3105

Otolaryngology-Head and Neck Surgery,

Facial Plastic Surgery, Allergy

(Continued next page)

Professional Listing Rates

Physician members of the Iowa Medical Society may advertise in this directory. Monthly rates are as follows: \$10.00 first 3 lines; \$2.00 each additional line. Billed yearly. May be prorated. Send or fax copy to Iowa Medical Society, 1001 Grand Avenue, West Des Moines, Iowa 50265-3599, fax 515/223-8420.

Iowa Head and Neck Associates, PC

Robert T. Brown, MD
Eugene Peterson, MD
Richard B. Merriek, MD
Peter V. Boesen, MD
Robert R. Updegraff, MD
 3901 Ingersoll
 Des Moines 50312
 515/274-9135

Dubuque Otolaryngology-Head & Neck Surgery, PC

Thomas J. Benda, Sr., MD
James W. White, MD
Craig C. Herther, MD
Thomas J. Benda, Jr., MD
 310 North Grandview Avenue
 Dubuque 52001
 319/588-0506

Otologic Medical Services, PC

Roger A. Simpson, MD
Guy E. McFarland, MD
Thomas F. Viner, MD
Douglas E. Dawson, MD
 540 E. Jefferson, Suite 401
 Iowa City 52245
 319/351-5680
 1-800/642-6217
Maxillofacial, Plastic, Head & Neck Surgery

Robert G. Smits, MD, PC

1040 5th Avenue
 Des Moines 50314
 515/244-8152
 1-800/622-0002
*Ear, Nose and Throat Surgery,
 Facial Plastic Surgery and Head and Neck Surgery*

Phillip A. Linquist, DO, PC

1000 Illinois
 Des Moines 50314
 515/244-5225
*Ear, Nose and Throat Surgery,
 Facial Plastic Surgery, Head and Neck Surgery*

Pain Management**Iowa Medical Clinic Outpatient Pain Treatment Center**

James R. LaMorgese, MD, FACS,
Neurosurgeon, Medical Director
Sandra Gannon, LSW, ACSW, Program Director
 600 7th Street SE
 Cedar Rapids 52401
 319/399-2013
Neurology, Psychiatry, Anesthesiology, Rheumatology

Perinatology**Des Moines Perinatal Center, PC**

Neil T. Mandsager, MD
 3408 Woodland Avenue, Suite 302
 West Des Moines 50266
 515/222-3060
*Maternal-Fetal Medicine
 Routine and Advanced (Level II)
 Obstetric Ultrasound
 Genetic Counseling
 Amniocentesis and CVS
 Antenatal Testing
 High-Risk Obstetrical Management
 High-Risk Deliveries*

Physical Medicine & Rehabilitation**Genesis Regional Rehabilitation Center**

Genesis Medical Center
 1227 East Rusholme Street
 Davenport 52803
 319/383-1466
Maurice D. Schnell, MD
Fareeduddin Ahmed, MD
Arthur B. Searle, MD
Bogdan E. Kryzstofiak, MD

Rehabilitation Medicine Associates

William D. deGravelles, Jr., MD
Charles F. Denhart, MD
Marvin M. Hurd, MD
William C. Koenig, Jr., MD
Karen Kienker, MD
Todd C. Troll, MD
Lori A. Sapp, MD
Yunker Rehabilitation Center
Iowa Methodist Medical Center
 1200 Pleasant
 Des Moines 50308
 515/241-6434

2600 Grand Avenue, Suite 102
 Des Moines 50312
 515/283-1570

Pulmonary Medicine**Fort Dodge Medical Center, PC**

Robert C. Aug, MD, FCCP
 800 Kenyon Road
 Fort Dodge 50501
 515/574-6820

Chest, Infectious Diseases & Critical Care Associates, PC

Roger T. Liu, MD
Steven G. Berry, MD
Donald L. Burrows, MD
Michael Witte, DO
Gerard A. Matysik, DO
Donald R. Shumate, DO
 1601 NW 114th, Suite 347
 Des Moines 50325-7072
 24 Hour 515/224-1777

Surgery**Wendell Downing, MD**

1212 Pleasant Street, Suite 410
 Des Moines 50309
 515/241-5767
Diseases and Surgery of the Colon and Rectum

Fort Dodge Medical Center, PC

Ralph E. Woodard, MD, FACS
Dan P. Warlick, MD, FACS
 800 Kenyon Road
 Fort Dodge 50501
 515/574-6865

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Why I belong

Iowa has a proud tradition of participation in organized medicine. Currently better than 4,100 physicians or 82% of eligible physicians belong to the Iowa Medical Society; approximately 75% of these belong to the AMA. I hope we will continue this tradition in the future.

There are many benefits to belonging to the Iowa Medical Society. Some are rather intangible, such as the results of efforts of physician committees and staff, representation in the Iowa Legislature, the Governor's office, state agencies and third party payers. Contributions to IMPAC—our bipartisan political action committee—help support the IMS efforts on vital issues such as reduced statute of limitations for minors.

There are also benefits for the individual and group practices such as the professional liability insurance, health, life, disability and worker's compensation insurance. The IMS provides administrative assistance to specialty societies, financial and retirement planning services, long distance telephone and overnight delivery service programs, practice management programs and debt collection.

Each year the IMS strategic plan is reviewed and updated to focus on physician needs. One of the important current issues is assisting physicians practicing in a managed care environment. The IMS is also helping physicians with CHMIS and data technology

management. Most importantly, the IMS is an advocate for the physician and the patient.

One complaint sometimes used as a reason not to join is that the IMS "doesn't represent my ideas or interests." IMS policy is set by the House of Delegates and those who wish to become a delegate can usually do so without a great deal of difficulty. This gives them the opportunity to express their views and enter the debate that shapes IMS positions on various issues. This does not mean that everyone is satisfied by the outcome of the vote but everyone has an opportunity for a fair hearing of opinion.

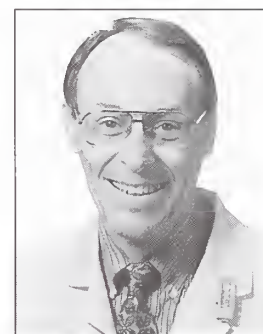
If you do not think your ideas or interests are being represented become a delegate.

Another option is to serve on one of the IMS committees.

Organization is the key to effectively advocating for patients and for many issues that face us.

We are the "keepers" of medicine today as were those before us and as will be those after us. We do it best through organizations

like the IMS. Join today! **IM**



JOSEPH HALL, MD

**Each year the
IMS strategic
plan is reviewed
and updated
to focus on
physician needs.**

IMS Update

AT A GLANCE

The fund-raising drive for the Iowa Medical Society Education Fund is underway. To date, seven pledges totaling \$14,600 have been received, plus \$7,600 pledged by other individuals. All IMS members are urged to consider contributing to the IMS Education Fund, the largest source of non-governmental loans for Iowa medical students.

According to a recent survey of 1,017 Iowa physicians, the biggest concerns in health care are quality vs. cost and government/insurance company involvement in health care. While 75% of respondents agreed physicians have more bargaining power in tandem with hospitals, only 16% said these physicians provide higher quality care than physician groups not in a partnership with a hospital.

PATIENT GRIEVANCES INCREASE

The number of patient grievances received at IMS headquarters has been on the increase. Most of these complaints are the results of poor communication.

Physicians are encouraged to take time to explain diagnoses and treatments to patients and their families. A little more time and demonstrated compassion can go a long way toward creating good will and possibly preventing liability claims. Remember, your office staff members play an important role in a patient's overall perception of the quality of care received.

Directory mailed; dues statements coming

The 1995-96 IMS Membership Directory is scheduled to be mailed soon to all IMS members. The directory contains a listing of all IMS members and other information regarding individual physician practices, county medical societies and specialty societies. On the back of the directory is a list by subject of the appropriate IMS staff member to call for information.

IMS 1996 dues statements are also scheduled to be mailed soon, with a message from Joseph Hall, MD, IMS president. Prompt payment of your dues will be appreciated.

Infant mortality continues to decline here

Iowa's infant mortality rate is continuing its decline, according to a report on 1994 Iowa vital statistics just released by the Department of Public Health. Fetal deaths (stillborns) dropped dramatically over the past year and the number of heart disease deaths dropped to expected levels after a one-year jump.

However, officials are taking a closer look at two categories of deaths — motor vehicle crashes and accidental deaths. The death

rate in both these categories climbed dramatically during 1994. The deaths caused by motor vehicles went from 16.5 per 100,000 Iowans in 1993 to 18.3. The deaths due to accidents went from 19.9 to 21.3.

For a free copy of *1994 Vital Statistics in Brief*, send a stamped, self-addressed envelope to: Center for Health Statistics, IDPH, Lucas State Office Building, Des Moines, IA, 50319-0075.

"Bridging Science and Program"

The national violence prevention conference to be held October 22-25 at the Des Moines Convention Center has been approved by the University of Iowa for 16

FOCUS ON IMS ALLIANCE

With the coming of the fall season and cooler weather comes the IMS Alliance Fall Board meeting in Amana October 11-12 and our national project **SAVE Today** (Stop America's Violence Everywhere). **SAVE** project events will be held annually on the second Wednesday of October, beginning October 11, 1995. Every medical Alliance is urged to do something on that day to focus attention on this devastating social problem which robs so many Americans of quality living.

At the Alliance's Fall Board meeting we are focusing on membership. Our speaker is nationally known columnist Marilyn Motes Kennedy. For 11 years, Kennedy was the "Job Strategies" editor for *Glamour* magazine. She is a frequent contributor to many national publications including *Working Women*, *Boardroom Reports* and *Modern Maturity*. She has appeared on "20/20" and "Good Morning America." Kennedy is past president of the Chicago Headline Club and the Chicago chapter of Women in Communications. She will conduct a mini-workshop on how to make the Alliance vital to our members. For more information, call Sandy Nichols at IMS headquarters, 515/223-1401 or 800/747-3070.

Contributed by Linda Miller, president, IMSA

credit hours of continuing medical education. The conference, entitled "Bridging Science and Program" is cosponsored by the Centers for Disease Control and the University of Iowa Injury Prevention and Research Center. Participants are expected from across the country.

For registration information, call the University of Iowa Conference Center at 319/335-3231.

SPECIALTY SOCIETY UPDATE

The Iowa Psychiatric Society has completed a survey of members' experience with the Iowa Mental Health Access Plan, currently contracted to Medco Behavioral Care Corporation of Iowa. A litany of problems with the program were outlined in the survey responses. The IPS Executive Committee is making plans to distribute the survey results to public officials.

The Iowa Psychiatric Society Annual Meeting is October 27-28 in Iowa City.

The Iowa Medical Group Management Association Annual Meeting was September 13-16 at Lake Okoboji. The theme of the meeting was "team building" and featured representatives of the Association of Iowa Hospitals and Health Systems talking about partnerships between doctors and hospitals and the new integrated delivery networks being developed around Iowa.

The American Medical Directors Association — Iowa Chapter held its annual meeting in Iowa City September 29-30.


The Iowa Society of Rehabilitative Medicine fall membership meeting was held Friday, October 6 at IMS headquarters. Topics addressed included-state and federal legislation and emerging organizations in the health care delivery system.

The Iowa Oncology Society will hold its annual fall membership meeting Friday, October 27 at the McFarland Clinic in Ames. Joseph Bailes, MD of the American Society of Clinical Oncology will speak on reimbursement and other issues.

The Iowa Association of County Medical Examiners Board of Directors met at IMS headquarters on Friday, September 29 to make final preparations for the annual meeting. The annual meeting will be Friday, November 3 at the Sheraton Inn in Cedar Rapids (note new location).

For more information about any of the above meetings, call IMS Services at 515/223-2816 or 800/728-5398.

Attention: Internet surfers

The American Medical Association now has a "home page" on Internet. The AMA page — which includes *JAMA* and other AMA publications — has been on the Internet since August 1. The AMA's Internet address is: <http://www.ama-assn.org>. 

**The American
Medical
Association now
has a "home page"
on the Internet.**

Opportunity Profile

Occupational Medicine

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(Career Practice Opportunity)

OccuSystems, Inc. is the largest national occupational health care practice management company in the U.S. today. We are currently seeking a primary care physician for our occupational health center in Des Moines, Iowa.

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Futures

Managed care prediction for Iowa

AT A GLANCE

Blue Cross and Blue Shield has unveiled HMO-USA, a nationwide Medicare managed care network that unites its member plans to extend Medicare managed care coverage across state lines. Fifteen independent plans have agreed to participate in a network that will cover 45 states. Iowa is not included in these 15 plans but probably will participate in the future. Minnesota and Missouri are part of the network.

Another PHO is under investigation by the Justice Department for possible antitrust violations. Justice is investigating to determine if the Baton Rouge, Louisiana Women's PHO, formed by a hospital and 144 ob/gyns on the medical staff, is monopolizing the area market and whether fee-setting constitutes price-fixing.

Managed care will dominate in Iowa within five years, according to a speaker at the 1995 Iowa Family Practice Opportunities Fair.

Ted Schwab, a partner in the management consulting firm of Schwab, Bennett and Associates, said managed care markets do not always follow an orderly development. They sometimes skip from first generation to third generation products (integrated delivery systems) quickly.

The cost of delivering medical care is going down, while premiums paid for care continue to rise, Schwab told his audience. This means someone is reaping the profits. Schwab discussed several models for who will benefit — in California, proprietary companies reaped the profits, in San Diego the hospitals got the profits and in Indianapolis the physician community led development of managed care and thus derived the profits.

He also discussed the potential growth of managed service organizations (MSOs) which will be the "integrators" in third generation managed care products. These MSOs will serve as experts on computer systems, data analysis, physician compensation, outcomes, operations management, etc.

Schwab cautioned that these integrators are not "retooled" hospital administrators or clinic managers because the skills needed are outside their experience.

Managed substance abuse treatment

The Iowa Department of Human Services (DIHS) and the Iowa Department of Public Health are jointly implementing a managed substance abuse treatment program to serve both Medicaid clients and non-Medicaid clients with income at or below 400% poverty level.

The Iowa Managed Substance Abuse Care Plan (IMSACP) began serving clients across Iowa on September 1.


The National Council on Alcoholism (NCA) has contracted with the Departments to implement the IMSACP with their subcontractor Medco Behavioral Care (MBC) of Iowa.

Clients served through the IMSACP will have access to substance abuse treatment through substance abuse network providers and, for Medicaid clients, through current hospital based substance abuse programs under contract with IMSACP.

Private practice physicians will be paid for office visits (billed under E & M codes) during which a physician determines that referral for substance abuse treatment is appropriate. DHS will notify physicians directly about this policy.

The provider toll free number is 800/836-8619. This number may be used for referral to a substance abuse treatment program through Medco or to obtain pre-authorization for treatment for Medicaid clients. For referral, physicians may also give the client number — 800/252-5881 — to patients.

Non-Medicaid clients may be referred directly to an IMSACP substance abuse provider network.

For questions regarding the new managed substance abuse care plan and its implications for Iowa physicians, call Barb Heck at the IMS, 515/223-1401 or 800/747-3070. 

MANAGED CARE INFO YOU CAN USE!

Beginning in January, Iowa Medicine will contain a special page on managed care. The *MANAGED CARE — NEWS YOU CAN USE* section will serve as an information source for IMS members and will contain managed care information from various publications, the AMA and a variety of other sources. *MANAGED CARE — NEWS YOU CAN USE* will contain a directory of materials available for loan to any IMS member.



CHMIS Update

As part of the Iowa Medical Society's ongoing effort to educate Iowa physicians about the Community Health Management Information System (CHMIS), this CHMIS Update page will be a regular feature in *Iowa Medicine*.

Progress toward the July, 1996 implementation of Iowa's CHMIS continues. Following is a compilation of recent actions of several subgroups appointed by the CHMIS Governing Board:

Ethics and Confidentiality — This advisory committee finalized a mission statement and a public education document concerning the release of two types of data from patient records: 1) **restricted access data**; and 2) **public domain data**.

Patients will not have access to data stored in the CHMIS data repository regarding their health care encounter. (Patient-identifiable data from records will never be released to any party.)

Patient data will be transmitted to the CHMIS data repository with the patient's social security number as a means of following encounters. However, social security numbers will be scrambled and never released to the public. The Governing Board believes data stored in this manner is no longer the patient's property, which means patients do not have the right to review and make corrections.

Restricted access data from patient records will be released only with Governing Board approval after the social security number has been scrambled. This data also includes zip code (five digits only), date of birth, sex, admit and discharge dates and procedure(s) and date(s).

Public domain data will be released, but only in generic, demographic form. (For example, someone's date of birth will be released as an age group.) The CHMIS Governing Board believes it is virtually impossible to identify someone from the public domain data base.

However, all data releases will include a number which identifies providers.

Technical — This advisory committee

has approved using the Electronic Health care Network Accreditation Commission's (EHNAC) national standards as a starting point to certify CHMIS networks. Administrative rules will be issued delineating other Iowa criteria networks must meet.

Also, the Technical Advisory Committee approved the Request for Proposal (RFP) for the CHMIS data repository. Both the network certification and the RFP will be forwarded to the September 15 Governing Board meeting for approval. It is expected that the Governing Board will allow interested vendors 60 days to submit a bid. A data repository vendor could be selected by the end of 1995.

The cost of CHMIS

The CHMIS Governing Board decided in June of 1995 that the party who benefits the most from an electronic transaction will pay the cost. This is being interpreted to apply to the entire cost — the fee assessed by "networks" to transmit a claim to the insurance company — now paid by physicians — as well as the CHMIS surcharge of one to four cents per transaction. If the Governing Board continues to follow this interpretation, the cost of electronic submission will be reduced for physicians.

Getting prepared

It is important for physicians to realize there are no certified networks at this time. The IMS will publish suggestions on how offices can meet CHMIS requirements in an upcoming *Iowa Medicine*. There will be many options for CHMIS compliance. Even if your office manually posts charges and payments and submits claims, it may not be necessary to purchase a computer.

For more information on CHMIS compliance or the activities of CHMIS committees, contact Ed Whitver at 800-747-3070.

YOUR representatives on state CHMIS committees:

CHMIS Governing Board:

Dale Andringa, MD
Des Moines
515/241-4102

Beth Bruening, MD
Sioux City
712/233-1529

CHMIS advisory committees:

Communications/Education
Laine Dvorak, MD

Data Advisory
John Brinkman, MD

Ethics/Confidentiality
Charles Jons, MD

Quality Review
Elie Saikaly, MD
William Langley, MD

Technical Advisory
Mark Purtle, MD

IMS CHMIS Committee:

Terrence Briggs, MD (chair)

IMS staff:
Ed Whitver
Barb Heck
Dean Gillaspay

Legislative Affairs

AT A GLANCE

Experts at gauging public opinion say Congress is still out of favor with citizens, with many believing Congress isn't moving quickly enough to trim spending and government. However, the pace will pick up during the next several months, with lawmakers voting on 13 spending bills, including a reconciliation bill to carry out the balanced budget resolution.

A wealth of governmental material can now be found on Internet's worldwide web, including the Federal Register, Congressional Record, US Code and other information. The web address is <http://www.sscsdc.ucsdc.edu/gpo>.

Managed care, scope of practice issues

The IMS Board of Trustees has approved the following priorities for the 1996 Iowa Legislature. The recommendations came from the IMS Committee on Legislation.

● Iowa Health Reform Transition Team

The Iowa Health Reform Transition Team is the successor to the Health Reform Council. The Transition Team may develop recommendations as legislation. The IMS participates in transition team activities and will evaluate recommendations as they are made.

● Coverage for Serious Mental Illness

The IMS opposes discriminatory benefit limitations, copayments or deductibles for the treatment of psychiatric illness under existing health care plans, and opposes discrimination in any proposed plans for national health care coverage or universal access for the uninsured.

● Liability Reform

Liability reform continues to be a top priority of the IMS. Efforts to reform the health care delivery system and to contain costs will not work without meaningful liability reform. The Board of Trustees will assess legislative and practice conditions in determining the best legislative strategy on liability issues. HF 394 reducing the extended statute of limitations for minors in medical malpractice cases passed the House in 1995 and is eligible for consideration in the Senate in 1996. This initiative will continue to be an IMS priority.

● Uniform Credentialing Form

The IMS supports the initiative of the IMGMA to develop and implement a uniform form for use by third party payers in credentialing of physicians. With the expansion of managed care, the completion of these forms has become an increasing burden on physicians and staff.

PUBLIC HEALTH ISSUES

● Universal Helmet Law

The IMS supports legislation which would require all motorcycle riders, including passengers, to wear approved headgear.

● Bicycle Helmets for Children

The IMS supports legislation to require children to wear protective helmets when riding bicycles.

● Tobacco Free Environment

The IMS has worked with the Tobacco Free Coalition for several years on legislation to provide a tobacco free environment for Iowans. Key coalition members in addition to the IMS are the American Lung Association, the American Heart Association and the American Cancer Society. The coalition is

IMS POSITION ON PHYSICIANS AND MANAGED CARE

The IMS supports the right of all physicians to apply to any managed care entity and be judged for admission based on objective criteria developed by physicians. These admission criteria should be based primarily on professional competence and quality of care.

Managed care organizations should be required to disclose to physicians the criteria used to select, retain or exclude a physician, including the criteria used to determine geographic distribution and number of specialty physicians needed.

The IMS opposes legislation which would require a managed care entity such as an IPA, HMO, ODS or PO to admit any physician or limited health care practitioner solely on the basis that the practitioner is willing to abide by the requirements of the entity. The IMS has worked with the major payers in Iowa to develop principles of agreement under managed care.

monitoring federal activities and will develop state legislative recommendations for 1996.

● **Review HIV/AIDS Laws**

An IMS Task Force has been appointed to review state laws governing HIV/AIDS to determine whether changes are needed. This process will include discussion with other organizations such as the Iowa Hospital Association, the Iowa State Bar Association and the Iowa Department of Public Health.

SCOPE OF PRACTICE/MANDATED BENEFITS ISSUES

Many issues relating to expansion of the scope of practice of limited health practitioners are being discussed this year. Health system reform efforts have provided a new forum for these issues in addition to the traditional approach of lobbying legislators for expansion of services allowed under a practice act. Issues which may be debated include the following:

● **Prescribing of a "Legend" Class of Drugs by Pharmacists**

The IMS believes that allowing pharmacists to prescribe drugs is not to the benefit of patients. While pharmacists play an important role as part of the health care team, because they are not trained in diagnosis and treatment of illnesses they should not be granted authority to prescribe drugs.

● **Expansion of Practice and Mandatory Coverage for PAs and Nurse Practitioners**

Various initiatives to expand scope of practice by reducing supervision requirements for PAs are expected as well as require third party payers to cover services for directly reimbursing PAs and NPs.

OTHER ISSUES

● **Limiting Copying Charges for Medical Records**

In 1995 legislation was passed by the Senate to require the department of Public Health to adopt rules to limit the amount that physicians and hospitals may charge attorneys for copies of medical records. The IMS and the Iowa State Bar Association have both approved Principles of Cooperation for Attorneys and Physicians which provide guidelines on appropriate charges. The IMS believes that use of such guidelines is prefer-

able to addressing the issue in state law.

● **Cremation Fees for County Medical Examiners**

The IMS supports an increase in cremation fees for County Medical Examiners from the current \$25 to \$50.

APPROPRIATIONS

● **Board of Medical Examiners**

The IMS believes that the Board of Medical Examiners should be fully funded through the appropriations process. Iowa law requires that physician license fees be set at a level to fund the operations of the Board. The IMS believes that revenue collected through this mechanism should be appropriated to the Board.

● **Medicaid Cost Containment**

Medicaid cost containment has been a major legislative issue for the last few years. Because of concerns about the growing Medicaid budget, legislators have mandated such cost containment measures as managed care plans and requiring prior authorization for certain prescription drugs. Even though the budget situation has improved for the current fiscal year, additional cost containment measures may be discussed.


● **Statewide Family Practice Residency Program**

The IMS supports funding for the Statewide Family Practice Residency Program. This program is essential for ensuring availability of family physicians to practice in both rural and urban areas of Iowa.

● **State Medical Examiner**

The IMS supports funding for the State Medical Examiner through the Department of Public Safety. Iowa's medical examiner system plays an essential role in public safety. Support and assistance for the state and county medical examiners will help ensure that the system functions properly.

NEW ISSUES FROM SPECIALTIES AND GROUPS — TO BE DISCUSSED AT NOVEMBER MEETING

- Reduced postpartum stays
- Violence in the emergency room
- Medicaid managed mental health care
- Emergency medical services definition 

Many issues
related to expansion
of the scope
of practice of
limited health
practitioners are
being discussed
this year.

Medical Economics

Final rule on Stark I self-referral law

AT A GLANCE

Some political observers are saying that product liability legislation (capping amounts of punitive damage awards and time limits for filing lawsuits) is in peril in Congress. The House and Senate passed product liability bills but left for the August recess without appointing conferees to settle differences. Trial lawyers are working hard to kill the proposals.

Welfare spending will be reduced in next year's budget. Programs such as Aid to Dependent Children, food stamps and benefits for low-income elderly will be trimmed at least 10%. However, welfare reform is no sure thing. The GOP and Clinton want it but are far apart on details and Republicans are bickering among themselves.

On August 14, the Health Care Financing Administration (HCFA) published its final rule on the Stark I physician self-referral law for clinical laboratory services. These regulations became effective September 13, 1995.

While these final regulations only address referrals to clinical laboratory services covered by Stark I, HCFA states that it intends to rely on language and interpretations in this rule when reviewing referrals for other designated health services covered by Stark II.

The deadline for commenting on the rules is October 13; the AMA has worked with state and specialty societies to develop comments on the rule. The AMA also continues working for legislative changes to physician self-referral as part of Medicare reform legislation.

Changes in earlier rules

HCFA has extensively revised the regulations from earlier proposed rules to reflect comments received. The changes include:

- revising the definition of "compensation arrangements" to clarify that it applies to direct and indirect arrangements;
- revising the "group practice" exemption to require that 75% of all patient care must be furnished through the group (unless the group practice is located in a Health Professional Shortage Area) and requiring an annual statement attesting that the group has met the test;
- revising the definition of "remuneration" to provide that forgiveness of debts, certain payments and furnishing of certain supplies and devices are not considered remuneration if they meet certain specified conditions;
- adding definitions of the following words and terms: "clinical laboratory services", "direct supervision", "hospital", "HIPSA", "laboratory", "members of the group", "patient care services", "physician incentive plan", "plan of care" and "transaction";

- revising the in-office ancillary services exception to require that individuals furnishing services be "directly supervised" by the referring physician or by another physician in the same group practice (the proposed rule had required that services be provided by an employee who was "personally supervised" by these physicians);

- providing that under the in-office ancillary services exception, group practices may furnish services in a building that is used for "some or all of the group's clinical laboratory services" (the proposed rule had required that the building be used by the group practice for centrally furnishing the group's clinical laboratory services);

- adding exceptions for qualified HMOs, and services furnished in an ambulatory surgical center (ASC) or ESRD facility or by a hospice and included in the ASC rate, ESRD composite rate or per diem hospice charge, respectively;

- revising the requirements relating to publicly-traded securities;

- revising the rural provider exception to provide that substantially all of the tests furnished by the entity are furnished to individuals residing in a rural area (the proposed rule had required that the physician office practices be located in a rural area); and

- revising several provisions regarding "exceptions to referral prohibitions related to compensation arrangements".

Each physician must bill for services

The final regulations do not include an exception for shared laboratories because HCFA states that it would not meet the statutory requirement that there be no risk of program or patient abuse. However, HCFA does state that "the in-office ancillary exception could apply if each of the individual physicians separately meet the supervision, location and billing requirements" of that section.

HCFA also makes it clear that the proxim-

ity of the laboratory to each physician's office is important, but that the physician may have his or her office in a location separate from the lab "as long as the lab is in the same building in which the physician practices or he or she fulfills the direct supervision requirement by being in the office suite when the tests are performed".

Finally, each physician — not the lab — must bill for services furnished to his or her own patients.

Because of the complexity of these regulations, the AMA recommends that physicians review the rule with their legal counsel in order to determine its impact based on their practice arrangement. Copies of the *Federal Register* containing this document may be ordered by sending a check or money order for \$8 payable to the Superintendent of Documents to: Government Printing Office, ATTN: New Orders, PO Box 371954, Pittsburgh, PA 15250-7954. Organizations with questions regarding these regulations or with comments on the final rule should contact Michael Ile of the AMA's Department of General Counsel at 312/464-5532.

Lawyers face increased malpractice suits

In a recent article entitled "Their Own Petard", the *Wall Street Journal* describes the growing trend toward suing lawyers for malpractice.

Such lawsuits once were rare, but more clients these days see lawyers as "just another deep pocket". They are suing over soured real-estate deals and disappointing trial outcomes and post-trial judgments.

To protect themselves, lawyers are beginning to take the same precautions they have forced upon other professions. They are screening clients more carefully, communicating better, involving clients more fully in strategic decisions and getting informed consent in writing.

"For lawyers, the irony of being hoist with their own petard is striking," said the *Journal*. "Lawyers did much to create the litigation frenzy now plaguing them by convincing people that for every setback, someone is to blame." **IM**

"They convinced people that for every setback, someone is to blame."

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AT A GLANCE

As of July 1, 1996, HCFA has mandated that all claims submitted to Medicare Part B be in the appropriate version of either the National Standard Format or American National Standards Institute format. Providers were asked in mid-1994 to schedule their transition to one of the approved formats in order to avoid delays which could force them back to paper claims. If you have questions, call the Provider Automation Assistance Center, 800/407-2067.

Last month, all IMS members were sent a one-page Medicare Q & A for patients, designed to educate senior citizens about basic Medicare issues and what went wrong with financing of the program. The Q & A is suitable for copying. If you did not receive one, call Bev Corron at the IMS, 515/223-1401 or 800/747-3070.

HCFA will reject truncated ICD-9 codes

As of October 1, HCFA began including truncated ICD-9 codes (those not coded to the highest degree of specificity) in its incomplete claim rejection initiative.

However, there will be a grace period until January 1, 1996 so the physician community can be educated, says a HCFA official. After January 1, carriers will reject claims submitted with a truncated code.

HCFA is cracking down on inadequate diagnosis coding for several reasons:

- Carriers handle truncated codes differently. Some pay claims, some develop, others deny. HCFA wants carrier policies to be consistent before the Medicare Transaction System is implemented.

- HCFA wants to resolve the inconsistency in carrier policy to enhance the quality of diagnostic data for research and policy analysis.

• More specific ICD-9 coding means better medical decision making by physicians, HCFA believes.

HCFA wants people to get flu shots

The Health Care Financing Administration (HCFA) has embarked on a campaign to educate Medicare beneficiaries on the value of annual flu shots. The message of the campaign is that flu shots are very beneficial for most senior citizens and other high risk groups and that Medicare will pay for them.

Part of HCFA's strategy is distribution of a consumer brochure aimed at the Medicare patient. Brochures are available free of charge to physicians who serve Medicare patients.

The IMS has brochures available. To obtain copies, call Sherry Johnson at the IMS, 515/223-1401 or 800/747-3070. **IM**

MIDWEST MEDICAL INSURANCE COMPANY FOCUS ON RISK MANAGEMENT

Confidentiality is the basis of a trusting relationship

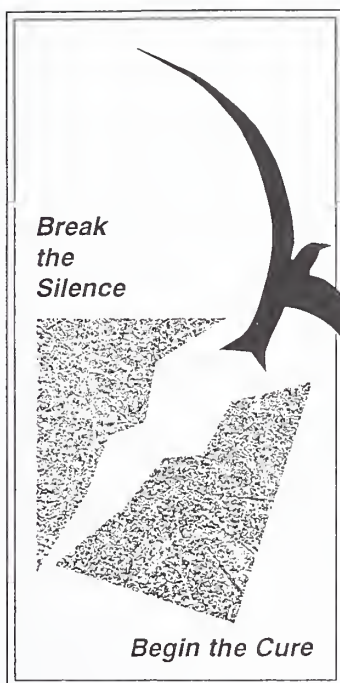
Confidentiality forms the basis of a trusting relationship between patients and health care providers. This relationship arises when patients trust you will respect their rights concerning personal information. The issue is not the privilege of the health care provider, but the right of the patient.

Confidentiality extends further than releasing copies of medical records only with patient authorization. There are many situations in which physicians and office staff can unintentionally breach patient confidentiality:

- Discussing confidential patient medical care in hallways or treatment areas where it can be overheard by other patients.
- Providing information to family members or friends without explicit patient authorization.
- Responding to telephone inquiries about a patient without proper verification of the caller's identity or the patient's authorization.
- Discussing a minor patient's treatment with a parent in a situation where the minor is entitled to consent to their own medical treatment.
- Leaving confidential messages at a patient's home or place of employment, or on an answering machine.

Be aware of these inadvertent releases of confidential information and make it everyone's job in your practice to protect patient privacy.

For further information, contact Lori Atkinson, MMIC risk management supervisor, MMIC West Des Moines office, PO Box 65790, West Des Moines, 50265, 800/798-9870 or 515/223-1482.



Yes, you should get involved!

Educational materials created by the IMS Task Force on Domestic Violence are now in use across Iowa and are getting excellent reviews from people inside and outside the medical profession. These materials, available to any IMS member, include:

- **A 27-minute commonsense video aimed at physicians but using an interdisciplinary approach to solutions.**
- **A handbook appropriate for use in your office as a one-stop source of practical information on identifying and managing victims of domestic abuse. Includes information on getting a restraining order and documenting abuse.**
- **Posters for your exam rooms or reception area.**
- **Hotline cards containing the IMS domestic violence logo and the statewide domestic violence hotline.**

To get materials or to learn more about the IMS campaign against domestic abuse, call Chris McMahon at the IMS, 515/223-1401 or 800/747-3070.

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Newsmakers

AT A GLANCE

Dr. Timothy Peterson, Des Moines emergency medicine physician, has received the 1995 "911 Team" Award from the American College of Emergency Physicians (ACEP). Award recipients are honored for immediate efforts, above and beyond the call of duty and their constant state of readiness to advance and promote the ACEP's advocacy program on the grass roots level. Dr. Peterson was specifically honored because his "work with Congressman Greg Ganske and his staff is an outstanding example of the dedication and persistence that characterize a 911 Team member."

IMS Task Force receives praise

Dear Editor:

I congratulate the IMS Task Force on Domestic Violence on the excellent job it has done on the videotape for physicians and the physician handbook. The physician handbook is a valuable asset for all physicians and I strongly encourage all members of the Iowa Medical Society to carefully review it.

Increased awareness and a few simple tools in better identifying victims of domestic violence have been valuable in my practice.—*Janice Kirsch, MD, Women's Health Center, Mason City*

Letter to the Editor

Dear Editor:

Thank you for the interest the Iowa Medical Society has shown for the problem of domestic abuse in our society. *Iowa Medicine* did a wonderful job of bringing the issue to the attention of the medical community last winter. And now, your video is particularly impressive!

Again, thank you for your interest and for your willingness to be part of the solution.—*Donna Walgren, director, Children & Families of Iowa, Des Moines*

Awards, appointments, etc.

Dr. David Hussey, professor and director of the Division of Radiation Oncology at UI Hospitals and Clinics, was recently named treasurer of the American Radium Society at the society's annual meeting in Paris. Members of the Linn County Medical Society have elected new officers: **Dr. Steven Eyanson**, president; **Dr. Wilson Strong**, president-elect; **Dr. Thomas Hansen**, vice president and **Dr. John Wollner**, secretary-treasurer. **Dr. Francois Abboud**, professor and head of internal medicine at the UI

College of Medicine, received the American Heart Association's prestigious Gold Heart Award during the association's 47th annual meeting in Dallas, Texas. Dr. Abboud served as president of the AHA from 1990 to 1991 and has been involved with the organization since 1958. Currently he is a member of the Iowa Affiliate Board of Directors. **Dr. Erin Herndon**, Des Moines, is the director of the newly-opened Mae E. Davis Free Medical Clinic. The clinic is one of five Healthcare Access Network clinics in Iowa providing free health care to insured and uninsured Iowans. **Dr. Jacquelyn Ryan**, **Dr. Nicolas Shammis** and **Dr. William Witcik** recently joined Cardiovascular Medicine, P.C., Davenport. **Dr. David Kragenbrink** has joined Drs. David Kemp, Kevin Franzen and R. Michael McGill in pediatric practice in Dubuque. **Dr. Sonia Sather**, third-year resident in the Cedar Rapids Family Practice Residency Program, has been named recipient of the 1995 Mead Johnson Award for Graduate Education. Two recent graduates of the Cedar Rapids Family Practice Residency Program are joining Cedar Rapids practices: **Dr. Nancy Angenend** has begun medical practice with **Dr. Carla Schulz** and **Dr. Daniel Vanden Bosch** is joining Drs. Carlton Lake, Brian Lindo, John Roof and Robert Swaney. **Dr. Alan Bollinger** has been appointed director of emergency services at Broadlawns Medical Center where he has assisted in the department for the past four years. **Dr. Janet Schlechte**, professor in the UI College of Medicine, Department of Internal Medicine and director of the UI General Clinical Research Center, received the 1995 Laureate Award from the Iowa Chapter, American College of Physicians. **Dr. Charles Lutz**, associate professor in the Department of Pathology, has been named to the editorial boards of the *Journal of Immunology* and the *Journal of Dental Research*. **Dr. Michael Pfaller**, professor in the Department of Pathology, has been appointed to the editorial board of the journal, *Antimicrobial Agents and Chemotherapy*. **Dr. R. Stephen Cooke** has joined Linn County

Anesthesiologists, P.C. Dr Daniel Fabiano (orthopedics) and Dr. Barry Scherr (family practice, rheumatology) have joined Dr. David Field in medical practice in Dubuque. Dr. Jonathan Knight has joined the Medical Associates Elkader office. Dr. Paul Seeborn, UI professor emeritus in the Department of Internal Medicine, has been honored by the American Academy of Allergy and Immunology for his service to the organization as a delegate to the AMA from 1973-94.

New members

Ames

Richard Stopps, MD, obstetrics/gynecology
Mark Taylor, MD, general surgery

Belle Plaine

Deborah Janicki, MD, family practice

Cedar Rapids

Leslie Kramer, DO, dermatology
Juanita Murawski, MD, psychiatry
Simon Wall, MD, psychiatry

Cherokee

Timothy Conrad, DO, resident

Des Moines

David Drake, DO, psychiatry
Joannie Franklin, MD, family practice
Roger Ganfield, MD, family practice/anesthesiology
Martha Senneff, MD, internal medicine/cardiovascular diseases
Brad Smith, DO, general surgery
Fred Stansbury, DO, internal medicine/oncology
Catherine Truesdell, DO, pediatrics

Dubuque

Mark Westfall, DO, emergency medicine/internal medicine

Elkader

Lynette Lamp, MD, family practice

Iowa City

Carlyn Christensen-Szalanski, MD, pediatrics
Eileen Comstock, MD, resident
Harriet Echternacht, MD, resident
Matthew Howard, III, MD, neurological surgery

Gene Lariviere, MD, general surgery
Edward Ricciardelli, MD, plastic surgery/otolaryngology

Ashish Sanon, MD, ophthalmology
Thomas Simpson, MD, resident
Theodore Wynnchenko, MD, resident

Osceola

George Fotiadis, MD, family practice
Alan Patterson, MD, family practice

Oskaloosa

Randall Hart, DO, family practice

Sergeant Bluff

David Sly, DO, family practice

Sheldon

Robert Thorbrogger, MD, radiology

Sioux City

Thomas Clark, DO, neurology
Benton Davidson, MD, neurology
Joe Kinzey, MD, family practice
Daniel Samani, MD, orthopaedic surgery

Spirit Lake

Jerome Perra, MD, orthopedic surgery

Waterloo

Cassandra Focns, MD, radiation oncology
Lawrence Furlong, MD, diagnostic radiology
Baz Hundal, MD, internal medicine

West Burlington

James Milani, DO, family practice

West Des Moines

Linda Lehman, MD, ophthalmology
John Nassif, MD, ophthalmology
David Saggau, MD, ophthalmology


Deceased members

Annette Fitz, MD, 62, internal medicine, Iowa City, died July 13

Mark Armstrong, MD, 74, internal medicine, Iowa City, died July 11

Michael Bonfiglio, MD, 78, life member, orthopedic surgery, Iowa City, died June 13

Clyde Meffert, MD, 94, life member, family practice, Cedar Rapids, died September 3

Seth Walton, MD, 88, life member, general surgery, Hampton, died June 14 

**If you have news
for this
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Iowa physicians and community hospitals . . .

Bound by **COMMON INTERESTS**

How can payer demands for reduced costs be met while maintaining strong cooperative ties between physicians and Iowa hospitals? The surest strategy may be vigorous physician-owned delivery systems which can retain market share which hospitals by themselves could lose to larger centers.

The pressure to reduce cost is mounting on physicians and hospitals throughout the country and Iowa is no exception.

Responses to these pressures are coming thick and fast; physicians are proposing to provide more services outside the hospital setting, thus avoiding its fixed costs and lowering the costs of procedures. Hospitals are acquiring physician practices and attempting to form PIIOs, but many payers are skeptical about their success because neither understands the extent to which these organizations must be operational and not merely marketing entities.

Iowa's hospitals and physicians, largely because they share the same community interests, have not been victim to the polarization which characterizes these relationships in other states. Urban hospitals have sought to expand by purchasing outlying physician practices and surgeons have moved significant portions of their practices to physician-owned facilities. However, a desire to preserve the peace prevails

between the two, though the peace may be uneasy at times.

How can payer demands be met while maintaining the strong cooperative ties between physicians and hospitals? It is possible that the surest strategy may be the emergence of vigorous physician-owned delivery systems which have the potential of retaining market share which the hospitals, by themselves, will surely lose to larger medical centers.

Payer dissatisfaction

Until this summer, writers were describing the failed Clinton administration initiative as the most recent attempt to change the system by which medical services are organized, delivered, managed and paid, but providers can take no comfort that the government pressure is off. Senate Republicans have just introduced their version of health care reform. Although this proposal is no where near as extensive as last year's, it contains many of the same flaws.

**The surest strategy
may be the
emergence of
vigorous,
physician-owned
delivery systems.**

COOPER PARKER

Cooper Parker is a principal with Physician Network Management, Inc. (PNMI) PNMI has offices in Des Moines and Oklahoma City.

Government initiatives aside, the marketplace has and will continue to exert its own demands for change, requiring action and response by physicians and hospitals. We read about the national purchaser coalitions which, through joint contracting, exacted discounts from California HMOs and we know that the same thing is happening — though with less dramatic success — in Iowa.

We hear of payer dissatisfaction with unseemly profits being stockpiled by HMOs while physicians and hospitals are squeezed and overall costs continue to climb. Corporate America is exerting pressure on insurers' rates (particularly HMOs), declaring their unwillingness to continue contributing to the HMO bottom line at the expense of their own. This turn of events, however, is only likely to increase the downward pressure on physician and hospital fees as HMOs attempt to decrease costs but not profits by decreasing medical costs.

Trend toward concentration of power

Compounding this problem is the trend we see toward concentration of power in the hands of a few insurance companies. Some industry analysts expect to see, within the next five to seven years, the concentration (by acquisition and merger) of power in the hands of 10-12 HMO giants.

Alongside government and market pressures, we see activity in Iowa which links hospital systems and attendant medical practices into competing systems. Hospitals

seek to retain market share by becoming a part of a more comprehensive system, thus keeping those services it provides well and appropriately within the community and making wider services available to community members at reduced prices. Quality and price considerations are addressed in a way which benefits the community.

Need for physician-oriented options

What of physicians' interests? In such an arrangement, whether it is a single hospital PHO or a multiple hospital/physician system, it is fairly easy to distinguish the hospital interest and to see how hospital resources are brought to bear to further hospital interests.

On the physician side of the equation, the picture is not so clear. The author was closely involved in the late 1980s in Hospital Choice Health Plan, an Ohio HMO owned by 23 hospitals in central Ohio, which included their medical staffs. The strategy was to preserve market share by linking rural hospitals and their staffs with Columbus hospitals and medical staffs.

While successful enough to attract favorable attention from Nationwide Insurance, leading to its acquisition by Nationwide, there were problems. An important one was that hospitals had staff and other resources to protect their interests but physicians did not and suffered

continued

On the physician side of the equation, the picture is not so clear.

Such organizations are not intended to replace PHOs. In fact, the physicians most committed to them are also usually the most active in their PHOs.

significant but unintended losses as a result. Hospital rates protected their fixed costs but physician capitations had no experiential basis and proved inadequate to support the utilization of medical services which occurred.

Physicians are fully occupied with busy practices and are not organized to deal with all the requirements of sophisticated negotiations with managed care entities or the demanding intricacies of overseeing an HMO.

Establishing a strong role for physicians

However, the environment is changing rapidly and dramatically. Recently, the AMA announced formation of its 'private sector advocacy and support team', whose function is to "help doctors finance their own health plans to battle for patients in the burgeoning managed care market".

Such organizations are multiplying everywhere, most notably in New Jersey, New York and Connecticut. PNMI has just recently completed a market audit and written a business plan for such an entity in Houston, Texas and has been engaged to do similar work for a physician-owned group in the Midwest.

It is also worth noting that the size of the groups varies widely. The largest group with which the author has been associated is the 6,000 physicians of the Harris County Medical Society in Houston, Texas; the

smallest is a nine-physician organization in South Texas. The common link is not size but commitment and willingness to stay the course.

Such organizations are not intended to replace PHOs. In fact, the physicians most committed to them are also usually the most active in their PHOs. They simply see the need for a strong and stable physician-oriented option to offer the marketplace.

Such entities establish a strong role for the physicians as an advocate for patients and as a clinical decision-maker. They also exemplify the possibility of effecting cost management through means other than reducing the physician fee schedule.

Physician-owned delivery systems demand certain conditions which include:

- Physician willingness to manage utilization.
- Physician willingness to forego high profits in return for a reasonable fee schedule and return of clinical control. (There must, of course, be an adequate consideration in the premium for administration of the plan, including utilization/management quality assurance, claims administration, marketing and product design.)
- Physician willingness to finance the enterprise and bear its risks.
- Physician willingness to operate a small business (grandiosity is a fatal flaw).

Two strong partners

How can such an organization help rural hospitals if they enter the marketplace in competition with the hospital's PHO?

Both entities seek to strengthen the other, but we have seen how physician resources are no match for those of even the smallest hospital. Two strong partners are more helpful to each other than a venture where one is weaker than the other.

Payers are looking for local solutions to their health care problems. In all the market audits done by PNMI, payers say they would much rather deal with local doctors and hospitals than with distant insurers who are taking dollars out of the community.

Physicians have a case to make to them about the danger of continued erosion of the integrity of medicine by insurers and HMOs. If this case is persuasive, local hospitals will also benefit. Hospital Choice Health Plan demonstrated what can happen to preserve the stability of local hospitals when their medical staffs organize themselves as financially responsible entities willing to take risks.

We are now seeing how local hospitals benefit when physicians take the additional steps of becoming independent and approaching the market as strong, vibrant alternatives to delivery systems which are causing unrest among both physicians and payers. **IM**

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Cardiology

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Contact Mercy Medical Center, Education Department, 701 10th Street S.E., Cedar Rapids, Iowa 52403, 319/398-6143

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Speaker: Frank Vinicor, MD, director of Diabetes Translation, Centers for Disease Control, president of the American Diabetes Association

Contact Iowa Methodist Medical Center, 1200 Pleasant, Des Moines, Iowa 50309, 515/241-5074

Fibromyalgia and the Link with Chronic Fatigue Syndrome Seminar

November 15, 1995

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Speakers: Mahammad B. Yunus, MD; Farid Manshadi, MD; William Collinge, PhD

Contact Staff Development, Covenant Medical Center, Waterloo, Iowa, 319/236-4058

Neurology

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The Journal

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Alzheimer's disease: the role of tacrine therapy

● GERALD JOGERST, MD

As the size of the elderly population expands, dementia becomes an ever-growing health problem. Dementing illness demands an increasing share of public health care resources and health care dollars. The elderly population of the U.S. makes up 12% of the national census. By the year 2030 it will account for 20%. Approximately 5% of those over age 65 are severely demented and an additional 10% exhibit some degree of intellectual compromise. Fifteen to 30% of those over age 80 suffer from a dementia. Since Alzheimer's disease is the most common cause of dementia, there is an increasing need for primary care physicians to diagnose Alzheimer's disease and to properly utilize therapies for dementing illnesses. Tacrine hydrochloride is the first drug released by the FDA for the treatment of cognitive deficits associated with Alzheimer's disease.

Dementia is not a part of normal aging, and patients presenting with dementia should be thoroughly evaluated regardless of age. Dementia is an acquired, sustained decline in intellectual function without alteration of consciousness. There is deterioration in at least two of the following spheres of intellectual function: memory, language, visual-spatial skills, personality and cognition (which includes the ability to abstract and calculate).¹ Alzheimer's disease accounts for approximately 50% of all dementia cases, vascular dementia 5% to 20% and combined Alzheimer's dementia and vascular dementia for 10% to 15%.² The onset is typically after age 65 and the disease is gradually progressive, leading to death in 6 to 12 years from time of diagnosis.³

Diagnosing Alzheimer's disease

Specific clinical features should be present

to diagnose Alzheimer's disease. These findings include progressive disturbance of memory, both recent and remote, as well as deficits in language, calculation, judgment and constructional skills.⁴ The neurologic examination remains normal until the terminal stages when motor abnormalities appear. The aphasia of Alzheimer's disease includes a fluent output, poor auditory and reading comprehension, preserved repetition and intact ability to read aloud. Behavioral changes include indifference and delusions, but severe depression is rare.

Routine laboratory studies contribute little to the diagnosis of Alzheimer's disease. MRI scans showing small hippocampus and temporal horns of the lateral ventricles may distinguish mild Alzheimer's disease from normal age-matched controls.⁵ Functional neuroimaging with positron emission tomography using fluorodeoxyglucose reveals bilateral parietal lobe hypometabolism early in the course of Alzheimer's disease. Neurochemical studies reveal loss of cholinergic enzymes from the cerebral cortex. The cholinergic involvement results from atrophy of the nucleus basalis of Meynert which is a sub-frontal cholinergic nucleus with extensive cortical projections. Norepinephrine, somatostatin and serotonin are also depleted in Alzheimer's disease. Since the symptoms of Alzheimer's disease are thought to be due, at least partly, to the depletion of acetylcholine in the brain, drugs are being developed to alter the effects of this depletion.

Pharmacological strategies to address the depletion of acetylcholine activity include loading patients with precursor substances necessary for acetylcholine synthesis. Lecithin has been used for precursor loading and has provided no benefit, but substantial

The IMS Education Fund has designated this article as the Henry Albert Scientific Presentation Award for October 1995.

GERALD JOGERST, MD
Dr. Jogerst is with the Department of Family Practice at the UI College of Medicine, Iowa City.

Alzheimer's disease: the role of tacrine therapy

continued

gastrointestinal side effects.^{6,7} Physostigmine, an anticholinesterase, has been associated with mild memory improvement in some patients.⁸ However, no overall gain in the activities of daily living accompanied the memory benefits.⁹⁻¹² Another strategy is to use muscarinic receptor agonists such as bethanechol.¹³ This too has proven unsuccessful.¹⁴ A newer therapy under investigation is the use of the monoamine oxidase B inhibitor, selegiline hydrochloride (Eldepryl), to reduce the oxidative stresses on at-risk cells and therefore delay cell destruction and acetylcholine depletion.¹⁵

Tacrine therapy in clinical trials

Tacrine hydrochloride is the first drug released by the FDA for the treatment of cognitive deficits associated with Alzheimer's disease. It is an orally bioavailable, centrally active, reversible cholinesterase inhibitor. Presumably, it increases acetylcholine concentrations in the cerebral cortex through slowing the degradation of acetylcholine released by still intact cholinergic neurons. Tacrine also blocks the uptake of dopamine, serotonin and norepinephrine and inhibits monoamine oxidase activity. It does not alter the course of the underlying dementing process. The drug effects may lessen as the disease process advances and fewer cholinergic neurons remain functionally intact.

Clinical trials carried out on tacrine included a double-blind, placebo-controlled study of 632 patients with mild to moderate mental impairment probably caused by Alzheimer's disease.¹⁶ The final six weeks of the trial was limited to 215 patients who demonstrated initial response to the drug. In this "enriched" population, patients treated with tacrine had smaller decline in memory and quality of life measures than the placebo group. However, clinicians could not detect a difference between patients taking tacrine or placebo. A secondary finding was a slower decline in instrumental activities of daily living in the tacrine treated group. A 12-week trial of 468 patients with mild to moderate impairment probably due to Alzheimer's disease demonstrated that patients on 40 mg per day for six weeks showed improvement in cognitive testing.¹⁷ Individuals who took 80 mg per day for the second six weeks showed

improvement in cognitive testing as well as clinical global ratings, meaning that clinicians could detect a difference. The cognitive tests used were the cognitive component of the Alzheimer's Disease Assessment Scale (ADAS-Cog) and the clinician-rated Clinical Global Impression of Change.¹⁸⁻¹⁹ There were no statistically significant changes in Mini-Mental State Examination (MMSE) scores.²⁰

The most recent clinical trial evaluated the benefits of tacrine dosages up to 160 mg/d over 30 weeks.²¹ Six hundred fifty-three Alzheimer's patients with MMSE scores of 10 to 26 were studied in an intent-to-treat analysis. The eligible patients were otherwise healthy. Patients treated with 160 mg/d of tacrine showed significant improvements on objective cognitive tests, quality-of-life assessments and clinician/caregiver-rated global evaluations. Lower dosages of tacrine resulted in marginal improvements. A total of 58% (384 patients) withdrew from the study before week 30, 74% (285/384) because of adverse effects. Only 28% (67/239) of the patients randomized to the 160 mg/d treatment arm were able to remain on the drug at 30 weeks. Those patients who were able to tolerate 160 mg/d improved on the ADAS-Cog by an amount equivalent to six months of deterioration in the course of Alzheimer's disease.²²

The most common adverse effect of tacrine is an increase in the serum alanine transferase (ALT). This occurs in nearly 50% of patients who take the drug and approximately 25% have an increase three or more times the upper limit of normal.^{23,24} Approximately 90% of these elevations occur within the first 12 weeks after initiation of treatment and most return to normal within six weeks after discontinuation of the drug.²⁴ Other side effects include nausea, vomiting, diarrhea, headache, myalgias and ataxia.

Tacrine appears to slow the decline or improve test scores in a minority of patients with mild to moderate Alzheimer's disease. No evidence exists in controlled trials that tacrine therapy leads to a substantial improvement in function. The drug can cause hepatic injury. Compliance may be a problem because of the need to take it four times a day. The cost is approximately \$120 for a one-month supply. Laboratory costs for the first four months of therapy are estimated at \$80.

90 per month and are reimbursed through Medicare. The benefits of tacrine for an individual patient can only be demonstrated by an adequate trial. In light of these findings what prescribing criteria should be used for this drug?

Criteria for initiating tacrine therapy

For individuals or families requesting tacrine, the following criteria for initiation of therapy seem reasonable. First, establish a diagnosis of Alzheimer's disease, mild to moderate in severity. This would exclude patients who are institutionalized because of severe cognitive and functional deficits related to Alzheimer's disease. Documentation of cognitive impairment should include a MMSE, clock drawing, and/or formal neuro-psychological testing.²⁵ Second, functional status which includes target deficits or problem behaviors identified by the patient's caregiver or physician should be evaluated on a regular basis. Third, since benefits may increase with higher doses, a commitment should be made by the patient and caregivers for a full trial of tacrine. The dose of tacrine is started at 10 mg Q.I.D. and increased as tolerated by 10 mg per dose every six weeks to a maximum of 40 mg Q.I.D. Finally, a visit to the physician every six weeks during dose escalation is necessary to review response and side effects of therapy.

Monitoring of therapy should include a baseline general chemistry screening that includes an ALT level. Obtain weekly ALT levels during dose escalation for not less than 18 weeks and every three months thereafter. For those patients without significant ALT elevation (less than 2 times normal) recommended interval for obtaining ALTs has recently changed to every other week for the first 16 weeks of therapy. An objective measure of cognitive function should be done prior to initiation of therapy as well as at six months. This testing can be performed by the prescribing physician or by physicians or psychologists with advanced training in the assessment of dementing illness. Caregivers' subjective impression of change should be reviewed at six week intervals. Adverse effects should be reviewed at each visit.


During the escalation phase of tacrine therapy, ALT levels less than three times the upper limits of normal should not delay

increased dosing. If the levels reach between three and five times the upper limits of normal, reduce the dose of tacrine by 40 mg per day. Then resume dose escalation once the ALT returns to normal limits. Tacrine should be stopped for ALT levels greater than five times the upper limit of normal. The patient may then be re-challenged with 10 mg QID and follow the original dose escalation schedule. Insufficient data exists on the risk of re-challenging patients with ALT levels greater than 10 times the upper limit of normal. Another indication to discontinue tacrine is clinical jaundice, confirmed by significant elevations of total bilirubin, greater than 3 milligrams per deciliter.

Conclusion

Tacrine is the only agent approved for the treatment of Alzheimer's disease. A small group of Alzheimer's patients tolerate the drug and show improvement in cognitive function or in clinician and caregivers' general impression of the course of the disease. There is no evidence from controlled trials that the use of tacrine leads to substantial functional improvement. The risk of hepatic injury requires weekly monitoring of liver functions test during the initial course. Tacrine is indicated in mildly to moderately severe Alzheimer's disease if the patient is willing to be closely monitored and the patient and family understand the drug's benefits and risks. There is no indication for tacrine in severely demented patients, including those admitted to nursing homes because of their cognitive deficits.

References

References noted in this article are available from the authors or the editors of *Iowa Medicine*. 

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A letter to your spouse

The first bond of society is marriage (Prima societas in ipso conjugio est).

Cicero

With this ring I thee wed, and with all my worldly goods I thee endow.

Book of Common Prayer

An article entitled "Have you written to your spouse lately?" by Raymond S. Kreienkamp (an attorney) in the August 1995 issue of *St. Louis Metropolitan Medicine* caused me to reflect upon responsibilities to our spouses. The message involves the responsibility to prepare our spouses so that our passage from this life leaves fewer questions and problems for the survivor.

Estate planning consists not only of preparing a will or trust, but informing your spouse of numerous facets of desires of the estate and the location of assets. Each spouse should prepare a letter to the other spouse (or another family member if there is no spouse) providing a myriad of informational data. The letter will assist the survivor with certain decisions that will need to be made during the first several weeks after the death. No professional assistance is required; just a personal letter of love and assistance.

Few people like to think about death, least of all adequately plan for that event. However, the letter in question should include per-

sonal desires for funeral arrangements. Obviously, the letter does not constitute a will and should be readily available rather than being locked in a safe box at the bank. Each spouse or other responsible survivor should know of the existence and the location of the letter.

Following are items that should be included with the letter: estate planning documents, names of advisors, data on life insurance, government death benefits, hospitalization insurance, financial data, balance sheets, bank account numbers, safe combinations, investments, outside loans and investments, home mortgage and abstract, tax files, credit cards, licensure information and location of auto titles, other assets, debts

No professional assistance is required; just a personal letter of love and assistance.

owed, allocation of personal items to selected persons, etc. The letter should be reviewed annually.

To have prepared for your demise to ease the burden on your spouse should constitute a final declaration of love. If we concur with Cicero that the first bond of society is marriage, our words to our surviving spouse seal that bond with finality.

If you would like to have a copy of Kreienkamp's paper call or write to me in care of *Iowa Medicine*. **IM**



MARION ALBERTS, MD

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Learning in a health care team

Note: This is a second of three articles on interdisciplinary CME.

Most practicing physicians are the product of an educational hierarchy in medicine. That hierarchy is structured by seniority and to a lesser extent by specialty. The entrance point is the first year of medical school; the education process typically occurs for at least seven years with the completion of residency. Throughout those years the physician-in-training acquires knowledge, skills and judgement, becoming part of a teaching hierarchy that includes the scientific and clinical faculty.

A revelation for many medical students is the realization during their training that their learning is enriched by clinicians other than physicians. How many of us gained our most useful insights into family function from a hospital social worker? How many of us acquired an appreciation of the assessment and management of pain from an experienced nurse? How many of us learned the rudiments of extremity rehabilitation from a physical therapist? How many of us learned about dietary options in compromised patients from a nutritionist? The answer to these questions is evident.

Our abilities as physicians have been enriched through work and communication with other health care professionals. Such experiences of course do not cease when we

complete our formal training, but they continue throughout active clinical practice.

It is then remarkable that we sometimes learn of physicians' reluctance to participate in organized CME activities that also include other health care professionals as participants. Some physicians may not want to acknowledge that their knowledge or skills are not always unique, but that at least some elements of that knowledge or selected skills may be relevant to the practice of other professionals. Alternatively, especially when the CME activity occurs in their practice community, physicians may conclude that a shared continuing education experience with other professionals might diminish their standing as specialists.

Our abilities have been enriched through communication with other health care professionals.

Many physicians embrace the notion that learning models should reflect practice reality. If the physician practices in an interdependent manner with other professionals, learning activities logically should be structured to be interdisciplinary. Several of our well-attended conferences at the University of Iowa are interdisciplinary courses dealing with diverse health care conditions such as arthritis, diabetes and AIDS.

The stature of the physician, as a member and leader of the health care team, is not only based upon the expertise of the physician, but also the understanding and respect shown by that physician toward all professional colleagues. **IM**



RICHARD NELSON, MD

Classified Advertising

General Surgeon BE/BC

The Department of Surgery at the Mayo Clinic, in conjunction with the Fairmont Clinic, is seeking 2 broad-based general surgeons to join a Mayo Regional Facility in Fairmont, Minnesota, 120 miles west of Rochester, Minnesota. This position offers an excellent opportunity to establish a surgical practice in an established 15-person Mayo-affiliated medical clinic in this town of about 11,000 with a 77-bed hospital and a service population of 45,000. This opportunity allows practice autonomy, a wide spectrum of general surgery, including some gynecological and orthopedic expertise and excellent salary and benefits. Inquires:

Michael G. Sarr, MD

Department of Surgery

Mayo Clinic

Rochester, Minnesota 55905

Mayo Foundation is an affirmative action and equal opportunity educator and employer.

Mankato Clinic, Ltd.—A progressive group practice is seeking additional BE/BC physicians in the following specialties: acute/urgent care, family practice, oncology/hematology, orthopedic surgery and general internal medicine practice. The Mankato Clinic is a 70-doctor multispecialty group practice in south central Minnesota with a trade area population of +250,000. Guaranteed salary first year, incentive thereafter with full range of benefits and liberal time off. For more information, call Roger Greenwald, Executive Vice President, at 507/389-8500 or Byron C. McGregor, Medical Director, at 507/389-8548 or write 1230 East Main Street, P.O. Box 8674, Mankato, Minnesota 56002-8674.

Assistant Residency Director, Department of Family Practice, University of Iowa College of Medicine—The Department of Family Practice at the University of Iowa College of Medicine is seeking an ABFP-certified physician to join the faculty as an Assistant Residency Director. Responsibilities include curricular design, procedural skills training and resident recruitment. The successful candidate will have practice experience and a minimum of one year teaching experience at the residency level and have competency in obstetrics. The department has a well-established 24-resident program that is university-administered, community-based and has admissions at community and university hospitals. The program is actively supported by both hospitals. A new model office facility is being built and expansion beyond the present one satellite rural office site is being pursued. As part of the full academic department, responsibilities include teaching, research and patient care. Academic appointment can be in either the traditional tenure track or a new clinical track. Scholarly activity is expected and supported. Appointment and salary commensurate with qualifications and experience. The University of Iowa is an Equal Opportunity/Affirmative Action Employer. Women and minorities are strongly encouraged to apply. Submit a letter of interest and CV to George R. Bergus, MD, Residency Director, Department of Family Practice, 2015 Steindler Building, Iowa City, Iowa 52242; 319/335-8456.

Des Moines—IM, FP, PD needed to join growing elite practice! Above average salaries, good call coverage, excellent benefits. Call Mary Latter at 800/520-2028! Job #M141MJ.

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Send CV or contact

Melissa J. Milliken, CMSC

ACUTE CARE, INC.

PO Box 515, Ankeny, IA 50021
800/729-7813 or 515/964-2772
Fax 515/964-2777

Emergency Medicine, Des Moines, Iowa—Opportunity to join an established emergency medicine practice at Iowa Lutheran, member of the Iowa Health System. BE/BC in emergency medicine or primary care specialty with experience. Call me to learn more about our department and generous compensation package. Contact Larry J. Baker, DO, FACEP, 700 E. University, Des Moines, Iowa 50316; 515/263-5263.

Springfield, Missouri—Bass Pro Shop and 40 miles to Branson. BE/BC FPs. OB optional, salaried position and production bonus, call 1:7, teaching hospital, university community. Contact Vivian M. Luce, Cejka & Co., 1/800-765-3055 or fax CV for immediate attention to 314/726-3009 (IMs welcome).

Escape from the ordinary!—General surgeon needed to work in our thriving rural family practice. Candidate should have skills in C-section, gyne and laparoscopic surgery. Eight weeks vacation/CME. Consultants available. Only group in county with 3 referral centers one hour away. Uniquely situated on I-94 half way between Madison and Twin Cities. Small town pride, excellent 51-bed hospital, great schools and recreation including all water sports, hunting, fishing, cross-country and downhill skiing. Cohesive group of caring physicians! Contact or send CV to Gary K. Petersen, Krohn Clinic, Ltd., 610 W. Adams St., Black River Falls, Wisconsin 54615; 715/284-4311.

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Seeking quality physicians interested in primary care and/or OB/GYN locum tenen opportunities.

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County Hospital**

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trained or emergency medicine
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- 60-hour weekend shifts (6 pm Friday to 6 am Monday)
- Approximately 45-55 patient volume per shift
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Family Practitioner—McFarland Clinic is actively recruiting a BE/BC family practice physician to assume the responsibilities of an established family medicine practice in central Iowa. Practitioner has support of over 80 medical and surgical sub-specialty physicians in same multispecialty group. Full privileges for a residency-trained family physician at Mary Greeley Medical Center, a 200-bed hospital in Ames, Iowa. Night call on a rotating basis at the Emergency Room at MGMHC. McFarland Clinic offers distinct advantages for the practicing physician in providing excellent compensation and benefits, practice management services and a generous retirement program, all in an environment which emphasizes physician cooperation and teamwork. For additional information, call or submit CV to Karen Andersen, 515/239-4535, McFarland Clinic, P.C., 1215 Duff Avenue, Ames, Iowa 50010.

Council Bluffs

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Clinic**

Seeking quality physician to practice either part, full-time or moonlighting during residency.

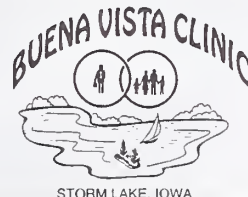
- Primary care, urgent care, occupational and sports medicine
- Weekday, weeknight and weekend shifts
- Paid St. Paul malpractice
- Excellent benefit/bonus packages

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Fax 515/964-2777

Family Practice Physician—Rare opportunity for a BE/BC family practice physician to join an established, progressive 8-physician practice in Marshalltown, Iowa, a thriving family oriented community 40 miles northeast of Des Moines. We have a beautiful new facility, a qualified staff and enjoy a supportive relationship with our 176-bed local hospital. Our philosophy is to provide personal, quality care to each of our patients, while maintaining our productivity, profitability and efficiency. This position offers an excellent benefit package, a voice in decision-making, 1 in 8 call and a very competitive salary/dividend package. For more information call or write to Michael Miriovsky, MD or James Burke, MD, Center for Family Medicine, PLC, 312 E. Main Street, Marshalltown, Iowa 50158 or call 515/752-5469.



Rural lakeside community provides unique setting for self-styled family practice. Employment with clinic foundation owned by county hospital means no buy-ins, 1:9 call coverage with weekend ER relief coverage, full employment contract with guarantee and excellent benefit package. You determine what patients to hand off in an outpatient hospital based referral system of 25 specialists. A+ schools, A+ recreations and A+ amenities. Send CV or call Darrell Pritchard, Administrator, Buena Vista Clinic, Box 742, Storm Lake, Iowa 50588; collect 712/732-5012; fax 712/732-2538.

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Job #C133MJ

(Continued next page)

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Internal Medicine and Family Practice Opportunities—Rural lake country community is seeking the above practitioners to join an active 13-physician multispecialty group. Quality, comfortable living environment, multiple recreational activities, fine educational opportunities and cultural activities abound. Opportunity includes relaxed call, liberal salary and exceptional benefits. Send curriculum vitae or inquiries to Lake Region Clinic, PC, Attn: Joel Rotvold, PO Box 1100, Devils Lake, North Dakota 58301 or call 800/648-8898 for further information.

Advertising Rates and Data

Regular classified advertising sells for \$2.00 per line with a \$30 minimum per insertion. For members of the Iowa Medical Society the rate is \$20 per insertion. Display classified advertising sells for \$25 per column inch, per month. Sizes range from 1 column by 2 inches to 1 column by 6 inches. A variety of type sizes, borders, reverses or screens can be included in the ad. Blind box numbers are available upon request at no additional charge. Copy deadline is the 1st of the month preceding publication. Send or fax copy to Iowa Medicine, 1001 Grand Avenue, West Des Moines, Iowa 50265-3599, fax 515/223-8420.

Director, Obstetrics and Gynecology—Broadlawns Medical Center, a 200+ bed county/community teaching hospital serving metropolitan Des Moines and Polk County, is seeking a well-rounded physician to direct the ob/gyn department. Activities will include supervising patient care teaching of family practice residents, a rotating ob/gyn resident and medical students in OB (500 births per year and growing). Department includes medical office clinical facilities, a Family Birthing Center with LDRP room accommodations; a Family Planning Program and mid-wife positions. Qualifications include an MD or DO degree, board certification or active candidacy of the American Board of Obstetrics and Gynecology, extensive practice experience and the ability to direct staff and programs to support the service and education goals of the facility. Clinical teaching experience is desirable. Post offer/pre-employment physical and drug screen required. This is a University of Iowa clinical appointment. Take the challenge and join our team! If interested contact D.J. Walter, MD, 1801 Hickman Road, Des Moines, Iowa 50314; 515/282-2203. Minorities and women encouraged to apply. Broadlawns is an Equal Opportunity/Affirmative Action Employer.

LeMars



Floyd Valley Hospital

Seeking quality primary care trained or emergency medicine physician to practice at FVH.

- 4300 average volume ER
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Vice President, Medical Affairs—Small regional health system in medium-sized Midwestern community seeks an experienced medical executive. Progressive managed care environment. Need a visionary who is strategic and quality-focused and has strong administrative/organizational skills. Great opportunity. Call or write Michael F. Doody, Witt/Kieffer, Ford, Hadelman & Lloyd, 2015 Spring Road, Suite 510, Oak Brook, Illinois 60521; 708/990-1370; fax 708/990-1382.

Family Physician—Family Medical Center is actively recruiting a BE/BC family physician to join 8 other family physicians and one general surgeon. Practice opportunity provides 1:9 call schedule, with full-time hospital ER coverage. Contract provides for attractive salary and excellent benefits. Send CV to Linda Cohrt, Office Manager, 1225 C Avenue East, Oskaloosa, Iowa 52577 or fax 515/672-2258.



Emergency Medicine Opportunity

North Iowa Mercy Health Center (NIMHC), Mason City, Iowa, is a private, not-for-profit, 350-bed medical center that services a 14+ county region in north central Iowa. For most of a century, NIMHC has combined the most advanced technology with compassionate care to provide our region with quality medical services.

We are seeking a **BC/BP primary care physician** with emergency medicine experience or an emergency trained physician for a full-time position in our facility. We invite you to become a part of our 4-member team in a modern ED with 23,000 annual visits and weekend double coverage. This position offers competitive compensation and an exceptional benefit package.

Mason City represents the best of the Midwest. It has quiet, tree-lined streets in modern neighborhoods and radiates that storybook "hometown" feeling. An incomparable lifestyle can be derived from the matchless public and parochial school system, a strong and growing economic base and the availability of ample recreational activities.

We would welcome the chance to discuss how this opportunity can fulfill both your professional and personal needs. For more information, please contact:

Laura Weis, Representative
North Iowa Mercy Health Center • c/o Mercy Health Services
4500 Westown Parkway, Suite 250 • West Des Moines, Iowa 50266
515/224-3260; 515/224-3546 (fax)

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Des Moines 50309
515/243-0590

Allergy & Immunology

Allergy Institute, PC

A.Y. Al-Shash, MD
R.K. Agarwal, MD
1701 22nd Street, Suite 201
West Des Moines 50266
515/223-8622

Pediatric and Adult Allergy, PC

Veljko K. Zivkovich, MD
Robert A. Colman, MD
1212 Pleasant, Suite 110
Des Moines 50309
515/244-7229

Asthma, Allergy & Immunology

Dermatology

Robert J. Barry, MD

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Cedar Rapids 52403
319/366-7541

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James D. Bunker, MD, FAAD
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Fort Dodge 50501
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Electrodiagnosis

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Staffing & Emergency Department Services*

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515/964-2772 or 1-800/729-7813

*Locum Tenens
Doctor on Call*

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**Chest, Infectious Diseases & Critical Care
Associates, PC**

Daniel H. Gervich, MD
Daniel J. Schroeder, MD
Ravi K. Vemuri, MD
Infectious Diseases
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Des Moines 50325-7072
24 Hours 515/224-1777

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West Des Moines 50266
515/222-3060

*Reproductive Endocrinology/Infertility
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Donor Oocyte Program
Artificial Inseminations
Reproductive Surgery
Menopause Management*

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Fort Dodge Medical Center, PC

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General Internal Medicine
William C. Robb, MD
Richard H. Brandt, MD, ABIM
Grace Z. Aug, MD

800 Kenyon Road
Fort Dodge 50501
515/574-6820

Neurology

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Laurence S. Krain, MD
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Cedar Rapids 52401
319/398-1721

*Neurology, EEG, EMG, Evoked Potentials
and Sleep Studies*

Fort Dodge Medical Center, PC

Jugal T. Raval, MD, MBBS
800 Kenyon Road
Fort Dodge 50501
515/574-6845

Neurosurgery

Iowa Medical Clinic

Neurosurgery
James R. Lamorgese, MD
Loren J. Monw, MD
600 7th Street, SE
Cedar Rapids 52401
319/366-0481

Practice limited to Neurosurgery

Hosung Chung, MD

2710 St. Francis Drive, Suite 401
Waterloo 50702
319/232-8756; fax 319/232-5703
Practice limited to Neurosurgery

Neurosurgical Services LLP

Robert Hayne, MD
Thomas A. Carlstrom, MD
David J. Boarini, MD

1215 Pleasant, Suite 608
Des Moines 50309
515/241-5760

Robert C. Jones, MD
S. Randy Winston, MD
Douglas R. Koontz, MD

2600 Grand Avenue, Suite 210
Des Moines 50312
515/283-2217

Neurological Surgery

Chad D. Abernathey, MD

1953 1st Avenue SE
Cedar Rapids 52402
319/363-4622

Neurological Surgery

Obstetrics/Gynecology

Fort Dodge Medical Center, PC

Brian L. Welch, MD
800 Kenyon Road
Fort Dodge 50501
515/574-6870

Ophthalmology

Wolfe Clinic, PC

Russell H. Watt, MD
John M. Graether, MD
Gilbert W. Harris, MD
James A. Davison, MD
Norman F. Woodlief, MD
Eric W. Bligard, MD
David D. Saggan, MD
Steven C. Johnson, MD
Todd W. Gothard, MD
309 East Church
Marshalltown 50158
515/754-6200

Satellite Offices

Lakeview Medical Park
6000 University Avenue, Suite 300
West Des Moines 50266
515/223-8685

804 South Kenyon Road, Suite 100
Fort Dodge 50501
515/576-7777

Sartori Professional Building
516 South Division Street
Cedar Falls 50613
319/277-0103

214 - 13th Street Southeast
Cedar Rapids 52403
319/362-8032

Ophthalmic Associates, PC

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Stephen H. Wolken, MD
Robert B. Goffstein, MD
Lyse S. Struad, MD
John F. Standler, MD, PhD
540 E. Jefferson, Suite 201
Iowa City 52245
319/338-3623

North Iowa Eye Clinic, PC

Addison W. Brown, Jr., MD
Michael L. Long, MD
Bradley L. Isaak, MD
Randall S. Brenton, MD
James L. Dummert, MD
Mick E. Vanden Bosch, MD
3121 4th Street, S.W.
P.O. Box 1877
Mason City 50401
515/423-8861

Timothy F. Moran, Jr., MD

United Federal Building
700 4th Street, Suite 305
Sioux City 51101
712/252-4333

Satellite Clinics

Horn Memorial Hospital
700 E. 2nd Street
Ida Grove 51445
712/364-3311

Orange City Hospital
400 Central Avenue NW
Orange City 51041
712/737-2426

General Ophthalmology

Orthopaedics

Iowa Orthopaedic Center, PC

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Sinesio Misol, MD
Joshua D. Kimelman, DO
Timothy G. Kenney, MD
Lynn M. Lindaman, MD
Jeffrey M. Farber, MD
Kyle S. Galles, MD
Scott A. Meyer, MD
Cassim M. Igram, MD
Rodney E. Johnson, MD
Martin S. Rosenfeld, DO
Teri S. Formanek, MD
Stephen M. Naruto, MD
Donna J. Bahls, MD
Jill R. Meilahn, DO
Jacqueline M. Stoken, DO
411 Laurel, Suite 3300
Des Moines 50314
515/247-8400

Orthopaedic Surgery

Fort Dodge Medical Center, PC

C. Mark Race, MD
800 Kenyon Road
Fort Dodge 50501
515/574-6880

Otolaryngology

Iowa ENT, PC

Thomas A. Erieson, MD
Marshall C. Greiman, MD
Steven R. Herwig, DO
Thomas O. Paulson, MD
Mark K. Zlab, MD
1-800/248-4443
1215 Pleasant, Suite 408
Des Moines 50309
515/241-5780

1200 35th Street, Suite 200
West Des Moines 50266
515/225-7761

Satellite Clinics:

*Pella, Perry, Newton, Indianola,
Oskaloosa, Guthrie Center, Knoxville*

Wolfe Clinic, PC

Michael W. Hill, MD
Daniel J. Blum, MD
309 East Church
Marshalltown 50158
515/752-1566

Lakeview Medical Park
6000 University Avenue, Suite 310
West Des Moines 50266
515/224-9533

Sartori Professional Building
516 South Division Street
Cedar Falls 50613
319/277-3105

*Otolaryngology-Head and Neck Surgery,
Facial Plastic Surgery, Allergy*

(Continued next page)

Professional Listing Rates

Physician members of the Iowa Medical Society may advertise in this directory. Monthly rates are as follows: \$10.00 first 3 lines; \$2.00 each additional line. Billed yearly. May be prorated. Send or fax copy to Iowa Medical Society, 1001 Grand Avenue, West Des Moines, Iowa 50265-3599, fax 515/223-8420.

Iowa Head and Neck Associates, PC

Robert T. Brown, MD
Eugene Peterson, MD
Richard B. Merriek, MD
Peter V. Boesen, MD
Robert R. Updegraff, MD
 3901 Ingersoll
 Des Moines 50312
 515/274-9135

Dubuque Otolaryngology-Head & Neck Surgery, PC

Thomas J. Benda, Sr., MD
James W. White, MD
Craig C. Herther, MD
Thomas J. Benda, Jr., MD
 310 North Grandview Avenue
 Dubuque 52001
 319/588-0506

Otologic Medical Services, PC

Roger A. Simpson, MD
Guy E. McFarland, MD
Thomas F. Viner, MD
Douglas E. Dawson, MD
 540 E. Jefferson, Suite 401
 Iowa City 52245
 319/351-5680
 1-800/642-6217
Maxillofacial, Plastic, Head & Neck Surgery

Robert G. Smits, MD, PC

1040 5th Avenue
 Des Moines 50314
 515/244-8152
 1-800/622-0002
*Ear, Nose and Throat Surgery,
 Facial Plastic Surgery and Head and Neck Surgery*

Phillip A. Linquist, DO, PC

1000 Illinois
 Des Moines 50314
 515/244-5225
*Ear, Nose and Throat Surgery,
 Facial Plastic Surgery, Head and Neck Surgery*

Pain Management**Iowa Medical Clinic Outpatient Pain Treatment Center**

James R. LaMorgese, MD, FACS,
Neurosurgeon, Medical Director
Sandra Gannon, LSW, ACSW, Program Director
 600 7th Street SE
 Cedar Rapids 52401
 319/399-2013
Neurology, Psychiatry, Anesthesiology, Rheumatology

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 West Des Moines 50266
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 Amniocentesis and CVS
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Genesis Medical Center
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 Davenport 52803
 319/383-1466
Maurice D. Schnell, MD
Fareeduddin Ahmed, MD
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Charles F. Denhart, MD
Marvin M. Hurd, MD
William C. Koenig, Jr., MD
Karen Kienker, MD
Todd C. Troll, MD
Lori A. Sapp, MD
Yunker Rehabilitation Center
Iowa Methodist Medical Center
 1200 Pleasant
 Des Moines 50308
 515/241-6434

2600 Grand Avenue, Suite 102
 Des Moines 50312
 515/283-1570

Pulmonary Medicine**Fort Dodge Medical Center, PC**

Robert C. Ang, MD, FCCP
 800 Kenyon Road
 Fort Dodge 50501
 515/574-6820

Chest, Infectious Diseases & Critical Care Associates, PC

Roger T. Liu, MD
Steven G. Berry, MD
Donald L. Burrows, MD
Michael Witte, DO
Gerard A. Matysik, DO
Donald R. Shumate, DO
 1601 NW 114th, Suite 347
 Des Moines 50325-7072
 24 Hour 515/224-1777

Surgery**Wendell Downing, MD**

1212 Pleasant Street, Suite 410
 Des Moines 50309
 515/241-5767
Diseases and Surgery of the Colon and Rectum

Fort Dodge Medical Center, PC

Ralph E. Woodard, MD, FACS
Dan P. Warlick, MD, FACS
 800 Kenyon Road
 Fort Dodge 50501
 515/574-6865

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PACs are a reality

In an ideal society, political action committees would not be needed. Whether or not you favor the PAC system, PACs are a reality and serve a function. I believe they enhance access to political candidates and members of state legislatures and U.S. Congress. PACs also provide groups and organizations with a way to get their candidates elected. If other groups with political interests fund a PAC, it seems to me that we must also do so to be sure that our interests are represented.

IMPAC, which represents Iowa physicians, is a bipartisan organization. Local IMPAC members assist in evaluating candidates seeking support. Previous voting records and demographics of a voting district are also used in determining support. If a legislator has not supported our position at least part of the time it is unlikely he or she will receive financial support from IMPAC.

IMPAC has done very well in supporting winning candidates. In 1992, 86 of the candidates supported by IMPAC won. In 1994, IMPAC was involved in 114 state races; 105 of these candidates won—a success rate of 92%.

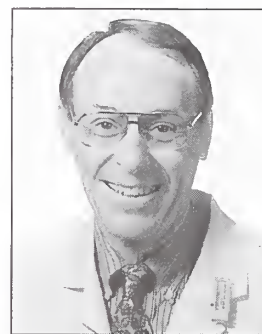
In 1992, IMPAC contributed \$92,000 to political campaigns. In the amount spent we ranked third as an individual group behind the Iowa State Education Association and Tax Payers United. However, the trial lawyers and the Iowa State Bar Association

ranked fourth and seventh and their combined expenditures were \$61,000 greater than IMPAC. In 1994, our contribution to state candidates was \$75,427, which dropped us to a ranking of sixth in PAC spendings. The trial lawyers jumped to fourth place spending \$78,000 and the Bar Association ranked seventh contributing \$74,500. As you can see, Iowa lawyers gave candidates for state office nearly twice the amount given by organized medicine. This makes it difficult to pass meaningful tort reform.

A portion of IMPAC dues go to AMPAC. AMPAC supported all four of our congressional candidates, contributing over \$30,000 directly and conducting polls for Dr. Greg Ganske and Jim Lightfoot.

**In 1994,
IMPAC was
involved in 114
state races;
105 of these
candidates won.**

Membership and contributions may wax and wane: politics never ceases. We are all aware of the political revolution taking place in Washington with the current congress. Columnist David Broder has referred to the current congress as one of the most significant in 40 years. All of us who contributed to IMPAC and supported candidates in various other ways had something to do with this. Our support of IMPAC must continue and increase. **IM**



JOSEPH HALL, MD

The right to privacy **VS** *The public's right to know*

Recent incidents have focused attention on Board of Medical Examiners (BME) activities in disciplining physicians. The key issue is what information is public and what is confidential during the investigation of complaints and in disciplinary proceedings by a licensing board against a professional licensed by the state.

Maintaining a balance between the rights of a licensee, the BME's need to obtain extensive, sometimes privileged information and the public's right to know is critical. Unfortunately, that delicate balance may be in jeopardy. In several cases, the statement of charges issued by the BME — a public document — has appeared to include information from complaint and investigative files. Complaint and investigative files and information they contain are specifically made confidential by law.

IMS concerned over "blurring" of lines

The IMS is increasingly concerned about the blurring of the lines between information which is specifically made confidential under state law and that which is public. Since the law's drafting and enactment in 1977, the IMS has supported the principle that the statement of charges is public when properly prepared.

When the statement of charges is public, agencies of state government are accountable. Public accountability protects patients and provides a means for elected officials, the public and the

group being regulated to monitor the activities of the regulators. The goal is to ensure that state regulators correctly implement the statutes.

This is the basis of the state's open records law and administrative procedures act. However, state laws also recognize that in order to maximize the flow of information to licensing boards, limits on public disclosure must exist. With regard to complaints against licensed professionals, the statutory limits are clear.

Disciplinary proceedings are considered contested cases under the Administrative Procedures Act, Chapter 17A, enacted in 1974. Since the notice of hearing in a disciplinary proceeding under Section 17A.12 was not specifically made confidential, it is a public record pursuant to the state Public Records Law enacted in 1967, so long as the notice was limited to the information required by Section 17A.12 and did not include information made privileged by Section 272C.6(4).

Section 17A.12 of the Iowa Code provides that the statement of charges is to contain only the following elements: the name of the licensee, a reference to the statute or rules alleged to be violated and a "short, plain statement of the matters asserted". Chapter 272C.6(4) limits what can appear in the short, plain statement contained in the notice by providing that complaint and investigative information is confidential. If

The statement of charges is public but the information it contains is strictly limited.

JOSEPH HALL, MD
Dr. Hall is a radiologist practicing in Des Moines. He is president of the Iowa Medical Society. This article was written in consultation with IMS legal counsel.

such confidential investigative information finds its way into the statement of charges, the statement is contaminated and its release violates the law.

The IMS has long supported the carefully crafted balance the law contains; the statement of charges is public but the information it contains is strictly limited. The IMS believes current statutes are violated when the BME files (and immediately releases to the press) statements of charges which contain investigative information, unproven allegations and other unnecessary narrative detail.

IMS position made clear in court

The IMS filed a petition of intervention and a statement of position in the much publicized case of John Doe II. These reiterate the position that a statement of charges which is contaminated with confidential information cannot legally be made public. The IMS does not assert that all statements of charges are confidential.

IMS representatives were actively involved in the legislative proceedings during the passage of the 1977 bill regulating licensed professionals. The purpose was to improve professional discipline for the protection of the public. The IMS supported the bill.

The legislation provided for the the maximum flow of information to licensing boards. Licensees are required to report to their respective boards negligent or careless acts or omissions of others licensed by the same board. Insurance companies are required to report "incidents" involving insured licensees which may constitute negligent or careless acts or omissions. Other persons are encouraged to report incidents. Licensing boards were given the power to require licensees to submit to physical or mental examinations which could be used against them. Sweeping powers were granted to licensing boards to obtain professional records "whether or not privileged or confidential under law".


As a result, the licensing board's complaint and investigation files contain information which has universally been considered privileged and confidential medical and mental health information, especially patient specific information and patient records.

The law balances the need to protect the public through effective license discipline against the public policy of protecting medical and mental health information, especially patient specific information and patient records. This balancing is expressed in Section 272C.6(4) by providing that the BME's complaint files, investigation files and other investigation reports and information are privileged and confidential and not subject to discovery or subpoena.

The BME has not been granted the authority to decide what information is privileged and confidential in their complaint and investigative files — it all is. Without this protection, people would be reluctant to file complaints and provide information, fellow professionals would be reluctant to be "informers" and patient records would not be forthcoming.

The law also provides for accountability by making public the final decision and findings of fact in license discipline proceedings and informal settlements. Each licensing board must file an annual report to the legislature including the number of complaints, judgments and settlements investigated by the board, the number of formal disciplinary proceedings commenced by the board and the number and types of sanctions imposed.

A careful balance

Effective license discipline requires the provision of the maximum information possible to the licensing boards while maintaining the privileged and confidential status of medical and mental health information, especially patient specific information. All in all, the law is a careful balance of conflicting public policies to achieve effective discipline. 

The law is a careful balance of conflicting public policies to achieve effective license discipline.

IMS Update

AT A GLANCE

In January, the IMS continues its educational effort in the area of violence prevention. The January issue of Iowa Medicine will be devoted to elder abuse. Experts will discuss how to recognize elder abuse, why elderly people tolerate abuse and physician reporting responsibilities.

Jamal Hoballah, MD, a surgeon in Iowa City, has been appointed to replace William Bonuey, MD as District II IMS Councilor. Dr. Bonuey has retired.

IMS dues statements were mailed in mid-October. Iowa is unified at the state and county levels. Prompt payment of your dues will be greatly appreciated.

Did you get your IMS Directory?

You should already have received your new 1995-96 IMS Membership Directory. The Directory contains a listing of IMS member physicians, a physician referral section and other pertinent information. If you have not received your directory, please call Sheryal Westbrook at the IMS, 515/223-1401 or 800/747-3070. Extra copies are available to IMS members for \$10.

SPECIALTY SOCIETY UPDATE

A presentation by Medco of Iowa on the first six months of managed mental health care for Medicaid patients highlighted the Iowa Psychiatric Society's Annual Meeting in Iowa City October 27-28. The IPS recently completed a survey of members and their experiences with Medco; results were shared with various governmental agencies and the Governor's office.

In recognition of Mental Illness Awareness Week, the IPS and several other organizations sponsored a conference on mental health insurance coverage at the Des Moines Botanical Center October 6.

The Iowa Association of County Medical Examiners Annual Meeting was held November 3 at the Sheraton Inn, Cedar Rapids.

The Iowa Association of Pathologists recently elected new officers for 1996-97: President — John Van Rybroek, MD, Iowa City; Secretary-Treasurer — Doryl Buck, MD, Cedar Rapids.

Roy Overton, II, MD, president of the American Medical Directors Association, Iowa Chapter, was appointed by the Governor as a delegate to the recent White House Conference on Aging.

New officers for the Iowa Medical Group Management Association are: President — Nancy Park; President-elect — Steve Hilpiper; Secretary — Denise Chaffee; Treasurer — David Lindner; Past President — Alice Eveleth. New board members are: Julie Barto, Joy Willis, David Weiss and Terry Stone.

For more information about any of the above meetings, call Dana Petrovsky or Dave Furneaux at IMS Services, 515/223-2816 or 800/728-5398.

Schedule change for Iowa Medicine

As part of the IMS strategic plan, the IMS Board of Trustees approved a reduction in the number of issues of *Iowa Medicine* which will be published each year.

The Journal, like other scientific publications across the country, has suffered from the loss of pharmaceutical advertising and skyrocketing paper costs.

Consequently, the Board voted to publish *Iowa Medicine* nine times each year rather than monthly. However, the Board stressed that the format of *Iowa Medicine* will remain the same.

Beginning in 1996, the following issues will be combined — May/June, July/August and November/December. A one-page newsletter will be sent to all members in June, August and December.

IMS video well-received in Des Moines

Representatives of the Des Moines business community, the Iowa Legislature, law enforcement and others attended the Des Moines premier of the Iowa Medical Society video "Break the Silence; Begin the Cure".

Bonnie Campbell, director of the U.S. Justice Department's Violence Against Women office, was the keynote speaker.

Ms. Campbell praised the Iowa Medical Society and the American Medical Association — in particular, past AMA President Dr. Robert McAfee — for their efforts in the area of family violence.

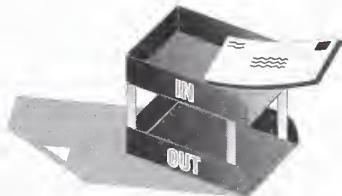
Also attending the Des Moines premier of the IMS video were Iowa Lt. Governor Joy Corning and Des Moines Police Chief William Moulder.

All three Des Moines television stations and WHO-radio did stories on the IMS video and the domestic violence education program. **IM**

Who?

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Futures

AT A GLANCE

A recent article in USA Today says the GOP plan to turn Medicaid over to the states faces three major stumbling blocks. The president will oppose it; interest groups will lobby hard against it and states that stand to see funding drops under the new plan will pressure their lawmakers to oppose it.

A recent study found that babies delivered by C-section and discharged within 24 hours of delivery are 3.3 times more likely to get sick enough for readmittance than if they stayed two or more days. The study also found that 58% of mothers with HMO coverage were discharged within 24 hours or less of delivery while only 36% of non-HMO mothers were discharged within 24 hours.

IMS continues meetings with Medco

Representatives of the Iowa Medical Society and the Iowa Psychiatric Society (IPS) continue meeting with officials of Medco Behavioral Care (MBC), the Department of Human Services and the Governor's office regarding concerns about managed mental health care for Iowa's Medicaid population.

The September *Iowa Medicine* contained a story which examined the first six months of operations by MBC, the company under contract with the state to manage mental health services for Title 19 patients.

The *Iowa Medicine* story outlined a number of concerns about MBC operations expressed by physicians, juvenile judges, legal services and other advocates for children. In the story, officials of Medco and the Department of Human Services (DHS) said Medco is working to correct problems.

The *Des Moines Register* also examined the issue in a lengthy story in its Sunday, September 18 edition. This story and a subsequent editorial explored the question of whether patients—especially children—are suffering because of Medco's policies.

In an attempt to work out problems, IMS and IPS staff have held frequent meetings with Medco representatives.

Late this summer, the IPS surveyed its members regarding Medco's policies and performance. Results of this survey were shared with the DHS, Medco staff and the Governor's office. A second survey is underway now.

Key issues discussed at the meetings include difficulty in certifying needed patient care, cumbersome processes, inappropriate claim denials and delays in claims payment.

In addition to special meetings, IMS and IPS staff also participate in a regular Provider Round Table hosted by Medco.

For more information about Medco claims payment, see story on page 440, the *Medical Economics* section.

Medicare debate 'laughable, tragic'

A recent editorial in the *Chicago Sun-Times* says the debate over the fate of Medicare has reached proportions which are "at once laughable and tragic". Those on both sides of the debate are being criticized for inundating the public with contradictory, inflammatory and mostly self-serving claims.

Meanwhile, James Todd, MD, executive vice president of the AMA, said the AMA's initial reaction to the Republican Medicare reform plan is "basically favorable". In particular, Dr. Todd cited a reduction in government regulation over laboratories and antitrust proposals.

Ethical implications of managed care

A coalition of New Jersey consumer groups is asking the state's Board of Medical Examiners to investigate the legal and ethical implications of managed care contracts that reward physicians for containing costs.

The group is also concerned about plans requiring physicians to sign agreements that bar them from discussing the organization's utilization review procedures. **IM**

IMS SERVICES OFFERS MANAGED CARE NEWSLETTER

IMS members can get the independent newsletter *Physician Network Insider* at a significant discount. The newsletter is published by United Communications Group (UCG) which also publishes *Part B News*.

The *Physician Network Insider* provides unbiased inside advice which can help physicians and their practice managers survive and prosper under managed care.

For more information, call UCG at 800/929-4824, ext. 223. (Mention the IMS.) You will receive a subscription form in the mail in the near future.



CHMIS Update

As part of the Iowa Medical Society's ongoing effort to educate Iowa physicians about the Community Health Management Information System (CHMIS), this CHMIS Update page is a regular feature in *Iowa Medicine*.

Progress toward the July, 1996 implementation of Iowa's CHMIS continues. Following is a compilation of recent actions of the IMS CHMIS Committee, the CHMIS Governing Board and several subgroups appointed by the Governing Board.

The Community Health Management Information System (CHMIS) Governing Board met September 15, 1995. The most important issue was approval of the Request for Proposal (RFP) for the data repository. The data repository will be the secure and confidential storage receptacle for storage of data collected by CHMIS.

Organizations interested in bidding on the data repository had until September 28 to send letters of intent and are to submit bids by November 15. The Governing Board will select a vendor by December 15, 1995.

IMS will not bid on CHMIS repository

The IMS Committee on CHMIS had recommended IMS staff seriously explore making a bid on the data repository; this was supported by the Board of Trustees. Since the IMS would not be able to undertake this project alone, staff met with the Association of Iowa Hospitals and Health Systems and a neutral third party experienced in electronic data transfers as potential partners to submit a viable bid.

However, after reviewing the RFP and deliberating about how the IMS could best advocate for physicians in the CHMIS process, it was decided not to submit a bid for the CHMIS data repository.

Primary concerns were the lack of time to develop software and test the system by July, 1996, an uncertainty about generating revenue to fund the repository and a requirement that the data repository vendor cannot have a vested interest in the outcome of the data. This last requirement seemed to effectively eliminate the IMS and its potential partners from the bidding.

No certified CHMIS networks yet

The Governing Board approved the first steps networks must take to become certified. Networks must first become accredited by the Electronic Healthcare Network Accreditation Commission (EHINAC), an organization committed to developing network standards across the U.S. Once networks become accredited, they must meet additional criteria which will be published in the Iowa Administrative Rules.

Keep in mind there are no certified CHMIS networks at this time. There probably will not be certified networks until close to the July 1, 1996 implementation date. There are software companies and potential networks traveling Iowa using CHMIS as a selling tool. **Physicians should be very cautious about any firm claiming to be a certified network at this time.**

What should physicians do?

The CHMIS Governing Board has made it clear that physicians who face a burden complying with the law will not be penalized on July 1, 1996 if they have a plan and are working to meet CHMIS requirements.

With this in mind, IMS staff recommend physicians wait until more decisions are made about CHMIS before expending funds to meet CHMIS requirements.

The best strategy is to stay informed about CHMIS developments and formulate a strategy to comply with the law. Do not panic and buy computer equipment and software because of a sales presentation. Watch for more guidance in future issues of *Iowa Medicine*.

The IMS Board of Trustees met recently with representatives of the CHMIS Executive Committee. Watch next month's Iowa Medicine for a report.

YOUR representatives on state CHMIS committees:

CHMIS Governing Board:

Dale Andringa, MD
Des Moines
515/241-4102

Beth Bruening, MD
Sioux City
712/233-1529

CHMIS advisory committees:

Communications/Education

Laine Dvorak, MD
Clarence Denser, Jr., MD

Data Advisory

John Brinkman, MD

Ethics/Confidentiality

Charles Jons, MD

Quality Review

Elie Saikaly, MD
William Langley, MD

Technical Advisory

Mark Purtle, MD

IMS CHMIS Committee:

Terrence Briggs, MD (chair)

IMS staff:

Ed Whitver
Barb Heck
Dean Gillaspay

Legislative Affairs

AT A GLANCE

In testimony before the Senate Labor and Human Resources Committee, AMA Trustee Palma Formica, MD, voiced strong AMA support for S. 969, which would provide mothers and babies with appropriate hospital coverage following delivery. The AMA believes physicians and patients should make discharge decisions without outside interference, said Dr. Formica. So far, 10 states have enacted legislation to protect mothers and newborns.

Murder charges against Jack Kevoorkian, MD have been dropped, but the retired pathologist faces charges of assisted suicide in the 1991 deaths of two women, the second and third of 25 he has attended. The AMA publicly deplored the decision to drop the charges.

More on PA rules

An agreement has been reached between the Board of Medical Examiners and the Board of PA Examiners on several issues relating to physician assistant supervision.

The joint rules review group composed of representatives of the two boards have agreed to continue the current requirement that a PA have one year of experience before practicing at a remote site where the physician is not always present.

The BPAE may reduce the requirement to six months through a waiver process if the supervising physician and PA have worked together at the same location for at least three months and the supervising physician reviews and signs charts documenting the PA's patient care at least weekly for the first year of practice at the remote site.

The current requirement of weekly visits by the supervising physician to a remote site has been reduced to every two weeks for PAs with more than one year of practice experience. Exceptions may be made for emergency circumstances.

Drug Therapy Management by Pharmacists

A new draft of rules has been issued by the Board of Pharmacy Examiners relating to drug therapy management by pharmacists. The new draft would replace those that were published for comment in June.

Several changes have been made to attempt to address IMS concerns about the rules; however, preliminary comments from members of the IMS Committee on Legislation indicate that the changes are not sufficient to receive IMS support. The IMS will share specific concerns with the Board of Pharmacy Examiners.

Contact Lens Prescriptions

The Board of Optometry Examiners has published rules for comment relating to the release of prescriptions for contact lenses and

spectacle lenses. The initial draft of the rules attempted to regulate ophthalmologists as well as optometrists.

Both the IMS and the Iowa Academy of Ophthalmology have sent comments requesting that the references to prescriptions by MDs and DOs be removed because the Board of Optometry Examiners has no authority over physicians.

BME Rules for Surgical Care

The Board of Medical Examiners has published rules for comment establishing standards of practice for preoperative, operative and postoperative patient care.

The rules provide that the surgeon of record in an operative case is responsible for rendering an appropriate preoperative diagnosis, selecting the operation to be performed in consultation with the patient, determining the patient's fitness for the operation, assuring that informed consent is obtained and managing the patient's postoperative care.

LEGISLATIVE VIDEOTAPE AVAILABLE

A videotape presentation is available to Iowa physicians who want information on the Iowa Medical Society's priorities for the 1996 Iowa Legislature. The tape is about 20 minutes long. On the video, physicians involved in the IMS legislative program discuss the IMS priorities and the impact of grass roots involvement in the political process.

As scheduling permits, Paul Bishop, IMS legislative liaison, will be on hand to answer questions after the tape is shown. The video would make a good program for county medical societies or specialty societies.

Copies of the tape are available for loan to IMS members. To borrow a tape or to arrange for a legislative briefing in your area, call Paul Bishop at the IMS, 515/223-1401 or 800/747-3070.

Postoperative care management includes delegating care to another qualified physician or delegating defined aspects of such care to an appropriately trained nonphysician practitioner. Fee splitting or giving or receiving fees in return for delegating postop care is prohibited. These rules codify a previously issued declaratory ruling.

For copies of any of these rules, call Becky Roorda at the IMS, 515/223-1401 or 800/747-3070, extension 618. **IM**

COMING NEXT MONTH . . .

Is your pension safe in the event you are sued? Read the December *Iowa Medicine* Legislative Affairs section for a legal opinion on pensions and Iowa law.

Opportunity Profile

Occupational Medicine

Des Moines, Iowa
(Career Practice Opportunity)

OccuSystems, Inc. is the largest national occupational health care practice management company in the U.S. today. We are currently seeking a primary care physician for our occupational health center in Des Moines, Iowa.

Occupational medicine experience is desirable but not required. We offer regular work hours with a limited rotating call. In addition, we guarantee an excellent starting salary along with a year-end bonus program. Plus progressive future growth and a comprehensive corporate fringe benefit program. The chosen candidate will assist in the development of the Des Moines, Iowa market.

If you are interested or would like additional information on this or other opportunities, call Jeff Moffett, C.M.S.R. or Matt Mear at 1-800-345-9958 or send your CV to:

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Dallas, Texas 75234

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Emergency Medicine Opportunity

North Iowa Mercy Health Center (NIMHC), Mason City, Iowa, is a private, not-for-profit, 350-bed medical center that services a 14+ county region in north central Iowa. For most of a century, NIMHC has combined the most advanced technology with compassionate care to provide our region with quality medical services.

We are seeking a BC/BP primary care physician with emergency medicine experience or an emergency trained physician for a full-time position in our facility. We invite you to become a part of our 4-member team in a modern ED with 23,000 annual visits and weekend double coverage. This position offers competitive compensation and an exceptional benefit package.

Mason City represents the best of the Midwest. It has quiet, tree-lined streets in modern neighborhoods and radiates that storybook "hometown" feeling. An incomparable lifestyle can be derived from the matchless public and parochial school system, a strong and growing economic base and the availability of ample recreational activities.

We would welcome the chance to discuss how this opportunity can fulfill both your professional and personal needs. For more information, please contact:

Laura Weis, Representative
North Iowa Mercy Health Center • c/o Mercy Health Services
4500 Westown Parkway, Suite 250 • West Des Moines, Iowa 50266
515/224-3260; 515/224-3546 (fax)

Medical Economics

AT A GLANCE

As House and Senate Medicare plans were unveiled, physicians were pleased that cries for regulatory relief had been heard. The House Ways and Means package exempts office labs from CLIA and modifies self-referral bans. Both packages add programs to fight fraud and abuse and both give medicine some long-desired concessions.

In the first antitrust lawsuits of their kind, the Justice Department charged yesterday that hospitals with local monopolies in Danbury, Conn. and St. Joseph, Mo., had joined with doctors in illegal price-fixing schemes to keep out lower-cost managed care companies.

Medco pays previously denied claims

Medco Behavioral Care (MBC), the managed care company under contract with the state to provide mental health services to Medicaid patients, has notified providers of several "claim action plans".

According to a recent communication from MBC to Iowa Psychiatric Society members, MBC will address "both retrospective and prospective claim improvements by addressing specific claim processing issues."

First, MBC plans to pay "all claims which have been denied due to a lack of precertification". According to MBC, about 12% of all billed charges were denied due to lack of precertification. Staff and provider training and education issues may have created unnecessary denials, said the Medco letter.

MBC also planned to pay claims received by November 1, 1995 for dates of service before August 31, 1995 which were not precertified.

In addition, eligibility for the Mental Health Access Plan (MHAP) is now being granted on a prospective basis only. Specifically, if a Medicaid client becomes eligible for Medicaid benefits in one month, the client's eligibility for MHAP will begin the first of the next month.

With this change and several training initiatives, the number of claims denied due to a lack of precertification should be considerably reduced, said MBC.

Medicaid debate heats up, too

Regions around the U.S. are fighting over the way Medicaid dollars would be distributed in new plans that have been proposed, such as block grants.

Governor Christine Todd Whitman of New Jersey, a Republican, and eight Republican House members from New Jersey complained that the Republican Medicaid bill would shortchange their state, shifting money away

from the Northeast to the South and the West.

Representative Michael Forbes, a New York Republican who calls himself a "loyal lieutenant" in Newt Gingrich's campaign to reduce the role of the federal government, says the Republican's proposed Medicaid formula is "absolutely unacceptable".

The proposal would force some hospitals on Long Island to shut specialized burn units and cardiac care units.

Marshfield verdict overturned

A federal appeals court has overturned a jury verdict that the Marshfield Clinic had created an illegal monopoly that kept Blue Cross and Blue Shield out of some parts of Wisconsin. However, the Court of Appeals upheld the jury's finding that the clinic had conspired with competitors to divide markets. The court ordered a retrial on damages due to Blue Cross; Marshfield appealed.

An amicus brief supporting Marshfield was filed by the AMA, the Medical Group Management Association and the Wisconsin Medical Society. **IM**

Practice Management

Data collection pilot project

Physician-specific data is being collected by insurance companies, the Iowa Health Data Commission and the Iowa Department of Public Health. This data will be part of the Community Health Management Information System (CHMIS).

The data is and will be used for many purposes — to include or exclude physicians in health care plans, to identify effective and efficient providers in treatment of certain diagnosis and to research practice variations in different areas of the state.

Many experts believe that physicians must take the lead in data collection, research, interpretation and dissemination. The IMS is attempting to determine member needs in data advocacy and technology and how the IMS can be of assistance to physicians.

For example, the IMS could provide additional insight into how data can be obtained, whether the data is valid, what studies are most beneficial to physicians and how the data can be used to counter information used by third parties.

The IMS is initiating a pilot project to determine member needs in the area of data. There will be a fee for participation. The project will involve development of practice specific reports and physician specific profiles for comparison to a confidential peer group.

Anyone interested in participating should call Ed Whitver at the IMS, 800/747-3070.

CLIA questions answered by fax

Brief but comprehensive information on commonly asked questions about CLIA regulations is now immediately available free to physicians and their staff. The same-day fax service is available by calling COLA Customer Service toll-free at 800/298-8044.

CLIA fact sheets will be faxed the same day to any physician or laboratory inquiring about a number of office laboratory-related

topics. The fact sheets condense information from a variety of sources into a user-friendly, one-page and two-page format.

There are 33 fact sheets covering topics including: how to properly register your shared laboratory with HCFA; requirements for microscopy procedures performed by providers; how to change your CLIA certificate; what to expect during a CLIA inspection; writing a procedural manual; and what labs should know about documentation. **IM**

MIDWEST MEDICAL INSURANCE COMPANY Focus on Risk Management

Is your clinic prepared for an emergency?

Whenever your clinic is open for patient treatment, your staff should be able to respond to a patient emergency. The type of emergency equipment, the level of staff training and the necessary emergency protocols are determined by your specialty, the type of procedures performed in the clinic and the foreseeable emergencies that may arise. Ensure that your clinic is prepared to handle emergencies by implementing protocols:

- Assess the emergency equipment and supply needs of your clinic. Oxygen, drugs and equipment should be available according to the procedures performed in your office.
- Inspect equipment routinely for functioning and schedule routine maintenance checks. Check drugs for expiration dates.
- Train staff in emergency response procedures and conduct periodic in-services to make sure all staff are aware of their roles and responsibilities.
- Determine appropriate limits on the types of patient contact that will be allowed without a physician present. Assess the risk of patient injury if the clinic allows non-physician staff to render routine treatment when there is no physician on the premises.

For further information, contact Lori Atkinson, MMIC risk management supervisor, MMIC West Des Moines office, PO Box 65790, West Des Moines, Iowa 50265, 800/798-9870 or 515/223-1482.

AT A GLANCE

HCFA's 1996 payment rates for Medicare HMOs for the 100 counties with the highest enrollment in risk-based managed care plans range from \$313.50 to \$760.66 a month. "The 1996 rates demonstrate that Medicare payment rates for managed care plans are moving in parallel with private sector payments," said Bruce Vladeck, HCFA administrator. As of July 1, about 2.8 million Medicare patients were enrolled in 167 risk-based managed care plans. There are no Medicare HMOs in Iowa, but projected rates would range from \$200 to \$400 per enrollee per month.

Most physicians have cut back or eliminated in-office lab testing since CLIA went into effect, a new study finds. The study comes on the heels of a federal study claiming CLIA has not adversely affected access to lab services.

Newsmakers

Another physician on the front line in WWII

Dear Editor:

Here is a story rarely heard about what happened to soldiers captured by the Germans in the Battle of the Bulge. In retrospect, the government made two boo-boos: (1) They took all the galoshes issued to the troops before coming to France; (2) They immunized the soldiers to every conceivable disease except diphtheria!

Soldiers in the Bulge stood in icy water for 36 plus hours. Their feet were frozen. Those unfortunate enough to be captured by the Germans were taken east of the Rhine, marched 40 miles up and 40 miles down the Rhine in the snow, before they were interned in a prison camp called Limburg. There they stayed for a month or so, together with some Russian prisoners. The Russian prisoners were fed fairly well and made to work. Our soldiers were treated with psychological measures such as starvation (with soup made of grass and other greens). They were kept in a basement compound. Once a day they would be given tiny bits of C rations from the Red Cross. Tiny pieces of chocolate or cheese or cookies. Afterwards the soldiers would reminisce about wonderful food they had at home. They knew that if they were sick they would get better food, so many of them laid next to a buddy with diphtheria, just to catch the disease and become ill.

At the end of their imprisonment they were skin and bones (like those at Auschwitz), lousy, with black feet from frostbite. Many died of starvation and other diseases. Many with diphtheria had complications I had never seen. Those who survived were transported to our General Hospital, GH #182, in the English Midlands. We cared for about 100 of those unfortunates. We fed their cachectic bodies slowly to avoid further complications, deloused

them, shaved them and treated multiple diseases prevalent as carry overs. I had seen diabetic gangrenous feet before and expected those black feet to be amputated, but to my surprise all of them got better without amputation! All survived except a few with severe hepatitis or pancreatitis.


I will never forget what tortures the so-called master race could conjure up. The aggressiveness is immediately under the surface in all of us.—Dr. Dan Glomset, Des Moines

Note: This letter was inspired by an article in the August issue entitled "Physicians on the Front Line". If you have a story to tell, send it to us; we'd like to hear from you.

Awards, appointments, etc.

Dr. Bery Engebretsen, director of Broadlawn Medical Center's Ambulatory Care Services in Des Moines, was recently honored with two prestigious national awards. The National Association of Community Health Centers presented him with the Samuel U. Rodgers Achievement Award for his outstanding contributions to the health center movement. Dr. Engebretsen was also presented with the Award for Excellence by the National Health Service Corps for his role in teaching and working with medical students. Three longtime Dubuque physicians recently retired from medical practice: Dr. Tom Benda, Sr., otolaryngologist; Dr. Fred Fuerste, ophthalmologist and Dr. Denis Faber, urologist. Dr. William Erkonen, UI Hospitals and Clinics, Iowa City, has been named a fellow of the American College of Radiology. Dr. Michael Chapman, orthopedics has joined Medical Associates in Dubuque. Dr. R.C. Wooters, Des Moines, has retired after more than 30 years of service as Polk County Medical Examiner.

Deceased member

John Baker, MD, 67, general practice, Mason City, died May 24 

AT A GLANCE

The Iowa Hospital Association has changed its name to the Association of Iowa Hospitals and Health Systems (IH & HS). Officials stated the change reflects the IH & HS mission to represent both hospitals and integrated health systems.

IHOPE, Health Occupations Partnership in Education, a formal association between Dubuque's Finley Hospital, Mercy Health Center and Northeast Iowa Community College (NICC), was signed into agreement in early August. This agreement marks a cooperative effort to provide continuing education opportunities for health care professionals in the tri-state area.

E & M coding . . .

Is IOWA COMPLYING WITH HCFA guidelines?

'Educate, not intimidate'

JOHN OLDS, MD

The American Medical Association introduced the new evaluation and management (E & M) codes in 1992. At that time, there was agreement that the Health Care Financing Administration (HCFA) would allow physicians an opportunity to become familiar with the codes before being subjected to Medicare audits.

In late 1994, the AMA and the HCFA jointly published E&M documentation guidelines. HCFA developed a documentation "score sheet" to be used by all carriers. In addition, HCFA instructed Medicare carriers to:

- Introduce the guidelines over six months (November 1994-April 1995);
- Implement educational monitoring over three months (May-July 1995); and
- Begin to audit and downcode E&M services as appropriate with dates of service August 1, 1995 or after.

As the carrier medical director, I am responsible for implementing the E&M documentation guidelines in Iowa.

Physicians have become increasingly anxious about Medicare's scrutiny of their documentation. While audits are a necessary process for all tax-sponsored programs, now is the time to educate, not intimidate. This is the reason considerable effort went into the educational monitoring process.

We conducted an educational Iowa audit for the monitoring period May-July, 1995. We randomly selected 150 E&M visits.

Each physician selected was asked to volunteer for an educational audit by submitting documentation for one E&M encounter.

In return, each physician was given the result of the documentation review, including the score sheet as completed by Medicare staff.

Though our sampling cannot be considered scientifically valid, some trends did emerge.

Inadequate attention to system review

Foremost was the lack of documentation of a review of systems as part of the patient's history. System review components could be found scattered in the record—usually in the history of present illness, sometimes as a separate review of systems entity and occasionally in the examination or assessment.

However, inadequate attention to recording system review too often led to a low level E&M encounter which otherwise would have supported a higher level code. Specifically, if no system review is performed, only the lowest level of history is justified.

The second documentation problem was found in the history of present illness. The category presenting many of the difficulties was the 'patient with a stable chronic condition' (i.e., hypertension or diabetes).

Often, the only history of present illness was "patient in for a recheck." This not only fails to describe the history of the

"Though our sampling cannot be considered scientifically valid, some trends did emerge."

continued



JOHN OLDS, MD
Dr. Olds, a Des Moines internist, is co-chair of the Medicare Carrier Advisory Committee and medical director for Medicare in Iowa.

present illness, but also leaves the reviewer guessing about what that illness might be.

Problems with exam component

Our monitoring results also show that physicians in subspecialties appeared to have more coding/documentation problems than family physicians and general internists. Much of this difference can be attributed to the exam component.

The only exam criteria available from HCFA at this time includes all body systems/areas and these are tailored to the presenting problem and physician specialty. Carriers are anticipating single system exam criteria from the national specialty societies and HCFA. If and when these become available, Medicare will publish the criteria.

Medical decision-making

Our chart reviews indicated that documentation of the physician's decision-making process was adequate to support the billed code. This is generally because decision-making flows from the findings on history and examination.

That is, the number of diagnoses or management options, the amount and complexity of data and the overall risk — the determinants of decision-making — depend upon the patient's presenting problem, which is characterized by the history and exam.

Summary

In addition to my responsibilities as the carrier medical director, I am a practicing physician. I recently documented consultations on two cases and decided to score my documentation using the HCFA guidelines.

What I found was my "gut reaction" code selection was not supported by my documentation. In both cases, I had

overcoded by one level of service. Like the E&M records I had been reviewing in my role as carrier medical director, I was lacking in a documented history and found the exam criteria restrictive for my specialty.

I encourage physicians to score their own documentation. This little scoring exercise took less than 30 minutes, but it made me aware of the scoring criteria as it applies to my specialty and identified where I need to concentrate my documentation efforts.

KENT MOSS, MD

Physicians can find out how well they are doing on E&M coding by implementing an ongoing monitoring system. We have done this in our office and each physician receives useful information about their own coding choices and substantiating documentation.

The program has been in place over four years, since 1992 when the new E&M coding system was implemented. Originally we used an outside firm, Partners Consulting Group, to help us establish our program, but now it is maintained by our reimbursement and coding staff as part of their job responsibilities.

There are three parts to our system:

- monthly statistical profiles
- medical chart assessment
- follow-up action, as needed

Monthly profiles

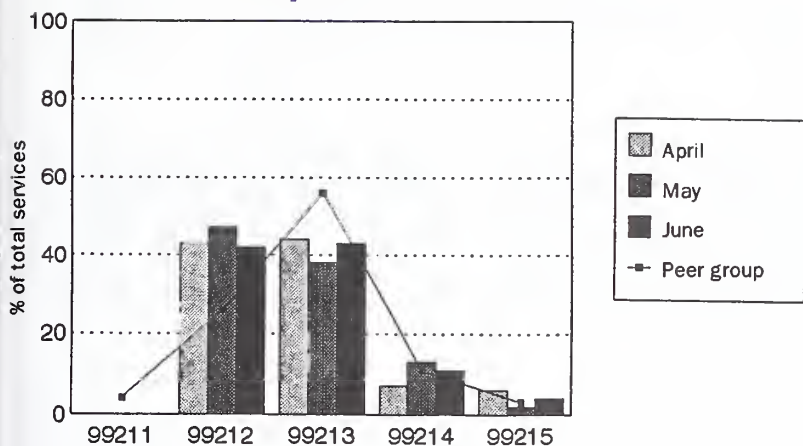
Each month every physician in our network receives his or her own code profile and worksheet. The profile shows a rolling three-month graph of the physician's utilization of the established patient office visit codes compared to peer group norms.

Review of the monthly graph is helpful for



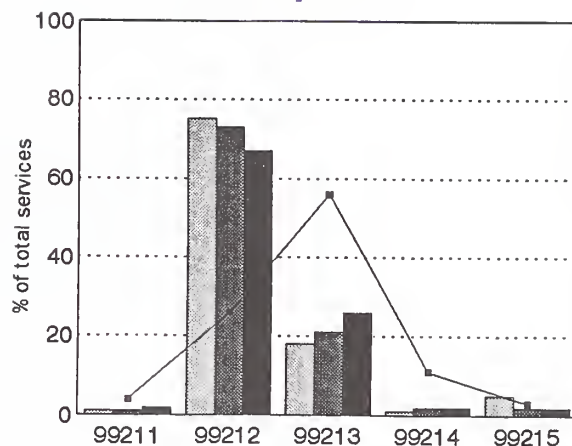
KENT MOSS, MD
Dr. Moss, an Algona family physician and member of the Mercy Family Care Network, is co-chair of the Medicare Carrier Advisory Committee.

Code profile



Graph A

Code profile



Graph B

identifying questions, trends and areas for action. Appropriate coding and changes in coding choices are also evident from the graphs.

Examples of individual profiles are shown in Graphs A & B. The physician profiled in Graph A shows a higher utilization of code 99212 than the peer group and may warrant additional review. The physician profiled in Graph B shows a trend toward decreasing use of code 99212, although still significantly above the peer group.

Chart assessment

Although we are currently doing actual chart assessments only twice per year for each physician, our goal is to provide the feedback quarterly. The chart assessment is done by our reimbursement coordinator. She compares the physician's documentation to the HCFA documentation guidelines and then determines if the billed code is substantiated. She uses various methods to select the chart samples, but averages 10-15 charts for each provider's assessment report. She uses the same "score sheet" the Iowa Medicare carrier uses to review documentation and feels it is consistent, accurate and works well for our monitoring.

The chart assessment report is compiled for the whole clinic, but each physician also gets his or her own results. Our reim-

bursement coordinator attends one of our regular monthly meetings to present the clinic report and identify areas for action.

Follow-up action

Education is our most common follow-up action so far. We have conducted on-site sessions at our clinics to review coding guidelines and documentation requirements.

The most effective sessions are when our physicians actually do chart assessment on their own documentation and "score" their own work. We find a physician can do one chart in about 10-15 minutes including discussion of the findings.

Don't be afraid to ask for help

Physicians need to pay attention to coding and documentation and we find an ongoing monitoring system helps them do that. The monthly profile graphs influence coding choices and chart assessments confirm good record documentation or highlight weaknesses in time to make improvements.

I encourage every physician to pay attention to their coding and documentation and seek help, if needed. Currently our system is not tied to compensation or incentives, but it could be in the future. And, if we are audited by HCFA, we have had a chance to analyze our coding and documentation practices before HCFA does. **IM**

For assistance or more information on HCFA's guidelines for E & M coding, call Barb Heck at the IMS, 515/223-1401 or 800/747-3070.

GREG GANSKE on Medicare reform

Contentious debate over Medicare reform continued last month as the Republicans introduced the Medicare Preservation Act. The first stop for the bill is the House Committee on Commerce, of which Iowa Congressman Greg Ganske, a physician, is a member. Rep. Ganske read this position statement to the committee on October 2.

I commend the chairman for a good start on the structural changes needed to preserve Medicare. There is much to like in this bill — free market options, regulatory relief, tort reform. It also takes courage to acknowledge that providers and recipients must share in this process of preserving solvency. However, this proposal is just a first step.

I am sure that many members of this committee will have good ideas on how to improve this bill's specifics. I, for one, hold that no political party holds a patent on truth or knowledge or good ideas. I look forward to reviewing amendments from both sides of the aisle. While I may not always agree, I promise that I will not reject an idea simply on the basis of party affiliation. The care of patients is just too important for back room party politics.

As a physician who has cared for thousands of Medicare patients, there are few issues I think are more important than the health of our senior citizens. There will be pressures on

members on both sides of the aisle to vote a party line. In this House of The People, no one should suggest that a member vote other than their conscience. How could any one of us live with adverse results affecting the health of our citizens if we did not vote our conscience? I call on the chair and the senior member of the minority party and the leadership of each party to pledge publicly and now that they will make no attempt to make any member vote against their conscience along party lines.

I look upon this mark-up as a wonderful way to improve your bill. I will be offering amendments ranging from consumer protection to home health care to graduate medical education to eliminating the differences in payment between rural and urban areas. I will also help defend parts of this bill I think are good. I know others are considering offering amendments on issues such as competitive bidding.

Besides the structure of this



REP. GREG GANSKE, MD

Dr. Ganske, a reconstructive surgeon from Des Moines, is the U.S. Representative from Iowa's Fourth District. He is a member of the House Committee on Commerce.

"The care of patients is just too important for back room party politics."

plan, there is the issue of its financing and the effects it will have. Let's tell the truth. We're in this fight because we're trying to balance the budget. The federal budget will never be brought under control until health care costs are under control. The Democrats know this, the President admits this and the Republican plan tries to implement it.

This brings us to the \$270 billion spending reduction goal of this bill. This is the number that fits. So much for defense, so much for agriculture, so much for welfare, so much for health care, so much for tax cuts. If you add to some, you must subtract from others.

My Democratic colleagues should also tell the truth. "Don't worry, be happy" arguments don't address the problem. They may not work politically in the short run and point in the wrong direction in the long run.

The dilemma we face is exemplified by statements of Cal Hershner, 68, of Cedar Rapids, Iowa, a retired school teacher. Mr. Hershner says, "I feel very strongly that \$270 billion is too much, too soon in a seven-year period. It will create a tremendous problem for Medicare recipients."

On the other hand, Mr. Hershner says, "I have five granddaughters and I don't want their economic futures jeopardized. I don't want to be dependent on my children for medical care or go back to an era when people depended on county homes."

I have worked in this system as a physician. I represent a large number of elderly. I have talked with administrators of small hospitals that are hanging on by a thread. I believe the goal of \$270 billion is too high in light of the fact that only \$30.8 billion of that is marked for structural

changes. The remainder will have to be made up by providers and beneficiaries.

I guarantee you these reductions would be bad for quality of health care for our senior citizens and our working families.

If Medicare and Medicaid cuts are too deep, hospitals and doctors will shy away from serving the elderly and the poor or will try to push costs to the non-elderly, which could further increase the number of uninsured. Or the quality of the whole health care system could decline.

There are three ways we can improve this health care bill: we can cut spending elsewhere, we can decrease the size of the tax cut or we can do both. I believe working families and senior citizens are served best by the first approach. The leadership can say they gave it their best shot with the Congressional Budget Office, fix these numbers and then declare a legitimate victory for common sense. I pray they do.

Congress might even consider adopting changes in the tax cut that 106 Republican members requested six months ago. This common sense approach would limit the upper caps on the family tax credit and focus the remaining tax cuts on provisions that would expand the economy.

I entered medical school over 20 years ago to help, not hurt people. I became a congressman to make a difference for working families and senior citizens.

In medical school, I learned the first dictum of medicine — *primum non nocere* — first, do no harm. I believe this dictum applies to the markup of this bill. A tourniquet can prevent hemorrhage, but too tightly applied can cause gangrene. **IM**

**"We can cut
spending
elsewhere, we can
decrease the size
of the tax cut or
we can do both."**

CME Seminars

AT A GLANCE

Advertise your continuing medical education seminars or workshops in this section by calling Jane Nieland or Bev Corron at the Iowa Medical Society, 515/223-1401 or 800/747-3070, fax 515/223-8420 or send copy and payment to Iowa Medicine, 1001 Grand Avenue, West Des Moines, Iowa 50265. Cost is \$25 per insertion up to 10 lines. Deadline is the first of the month preceding publication.

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Did you know . . .

Federal health officials now recommend coronary bypass surgery over angioplasty for diabetics with coronary artery disease because of surprising long-term findings from the world's largest study of the two heart procedures.

The National Heart, Lung, and Blood Institute (NHLBI) recently issued a clinical alert about patients with Type I or II diabetes who are being treated with oral hypoglycemic agents or insulin and have multivessel coronary artery disease. These patients have a markedly lower death rate when a first revascularization is done with coronary artery bypass graft surgery than with percutaneous transluminal coronary angioplasty.

The finding comes from the NHLBI-funded Bypass Angioplasty Revascularization Investigation, an 18-center international randomized trial. For more information call the NHLBI Information Center at 301/251-1222.

Is your medical staff or county medical society looking for a CME program idea? Why not consider the Iowa Medical Society domestic violence videotape!

This 27-minute video is getting rave reviews from physicians and other health care professionals, clinic managers and domestic violence advocates.

The video contains Iowa domestic abuse experts and is aimed at educating Iowa physicians on how to manage victims of domestic abuse.

Any IMS member physician may borrow the videotape by calling Chris McMahon, IMS director of communications, at 800/747-3070 or 515/223-1401. IMS staff can also provide written materials to accompany the videotape.

**Don't miss out on this opportunity to learn more about domestic abuse in Iowa
and how you can help your patients.**

The Journal

of the Iowa Medical Society

Apnea and vomiting in an infant due to cocaine exposure

● ENEIOMERE OKORUWA, MD; RIZWAN SILAH, MD; KAREN GERDES, MD

The introduction of smokeable cocaine (crack) in 1980 has resulted in epidemic cocaine abuse in the U.S. Data concerning effects of maternal cocaine use on the fetus and infant have referred mainly to those effects produced by transplacental transfer of drugs into fetal circulation and the impact of perinatal cocaine exposure on infants and children. Cases of cocaine exposure in infants resulting from maternal breast milk have been reported. The following is a case report of an infant with episodes of apnea and vomiting as a result of passive exposure to cocaine.

Case report

A 36-day-old female presented to the emergency room with a history of multiple episodes of apnea on that day, each of which required stimulation. Some of the spells were associated with vomiting, eye rolling and limpness. There was no cyanosis, fever, shaking, tremor, diarrhea, upper respiratory infection symptoms or history of acting ill prior to the apnea. There was a history of self-limiting apneic spells at six and 15 days of age. She was a product of a term pregnancy complicated by polyhydramnios and was delivered by Cesarean section for fetal bradycardia. Birth weight was 5 pounds and 15 ounces. She was on Similac with iron and had a hepatitis B immunization five days prior to presentation.

On physical examination at the time of admission, she weighed 8 pounds and 12 ounces. Significant findings included missing middle phalanges on both index fingers and syndactyle of the second and third toes bilateral. While in the emergency room, she had an apneic episode accompanied by arterial blood desaturation to 68% and a blank stare,

lasting for less than one minute, which responded to stimulation.

The results of lab evaluation including complete blood count, serum electrolytes, BUN, calcium, iron, phosphorus, creatinine, uric acid, and alkaline phosphatase were within normal limits for age. Urine drug screen was positive for cocaine metabolite benzoylecgonine (571 ng/ml). No other drug or drug metabolite was found in the urine. Chest x-ray, unenhanced head CT and EEG were normal. Nasopharyngeal wash for respiratory syncytial virus was negative. The mother's urine was positive for benzoylecgonine and tetrahydrocannabinol.

No subsequent apneic episodes were observed during four days of hospitalization. The baby was discharged on an apnea monitor to the care of her grandmother following referral and consultation with child protective services. Seven months after discharge, the baby was doing well and had had no additional apneic spells.

Discussion

Cocaine use in the U.S. is significant. Twenty percent of 30 million Americans who tried the drug in 1988 have gone on to be regular users and 5% compulsive users.¹ The incidence of fetal exposure to cocaine may be as high as 15% in some communities. In 1987, for example, cocaine was isolated from the urine of more than 15% of newborn infants at Harlem Hospital, New York.²

Prenatal cocaine exposure may result in fetal hypoxia secondary to cocaine-induced vasoconstriction. Congenital malformations resulting from vasoconstriction and fetal hypoxia included dysgenesis of the extremities, abnormalities of the genito-urinary tract

The IMS Education Fund has designated this article as the Henry Albert Scientific Presentation Award for November 1995.

**ENEIOMERE OKORUWA, MD
RIZWAN SILAH, MD
KAREN GERDES, MD**

At the time this article was written, all three authors were associated with Blank Children's Hospital, Des Moines. Dr. Okoruwa currently practices in Council Bluffs.

Apnea and vomiting in an infant due to cocaine exposure

continued

like prune belly syndrome and hypospadias, ileal atresia, seizures and cerebral infarction.¹ Behavioral impairments including poor organizational responses to environmental stimuli and depressed interactive behavior have been reported.¹

Postnatal cocaine exposure has been reported to result in generalized seizures, acute hemorrhagic diarrhea and cardiovascular collapse, tachycardia and hypertension and infant death.³⁻⁶ In addition, some of these infants also have abnormal sleep patterns, increased irritability, poor feeding habits and tremors.

Apnea associated with vomiting in infancy is often attributed to gastroesophageal reflux and aspiration. These common symptoms should be carefully evaluated with detailed feeding history, family and social history and inquiries about drug habits of all caretakers and household members. While blood and urine toxicology may not be indicated for all patients who present with apnea and vomiting, it definitely may be of value in a high risk population when etiology is unclear, routine work up is negative and the patient's symptoms resolve while in the hospital and without any medical intervention.

Our patient and her mother had significant levels of cocaine metabolites in their urine. The half-life of cocaine is approximately one hour. The drug is metabolized by plasma esterases and the liver microsomal enzyme system and eliminated in urine mostly as inactive metabolites. The source of the

cocaine was not breast milk because the patient was on a regular infant formula. The most likely source of exposure would be passive inhalation of cocaine smoke from care provider's drug use.

Public education needed

Health care professionals should inform patients about harmful effects of passive cocaine exposure on young infants and children. An ongoing educational effort for public awareness regarding prevalence and impact of passive cocaine exposure should be a priority among public health professionals. Physicians need to become more involved in health promotion through public education.

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Attention All IMS Emeritus and Life Members

Recently you received a letter regarding *Iowa Medicine* magazine. A postcard was enclosed which must be returned no later than December 1 if you wish to continue receiving the journal. If you haven't received the letter and postcard and want to remain on our mailing list, give us a call at 800/747-3070 or 515/223-1401 (ask for Jane Nieland or Bev Corron).

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Have I been a good parent?

Thirty-eight years ago Jeannette and I became first-time parents. This was an "A.M."* occurrence; quite different than with so many in recent years. Now, as I ponder over the past 38 years I ask myself, "Have I been a good parent?" I am prompted in asking this question by a column by John Rosemond which appeared in the *Des Moines Sunday Register* on September 17, 1995. Rosemond, the prolific writer as a family psychologist, avers "Permissive? Nah, today's parents are just plain wimps." He admits to being a recovering wimp, having in previous writings admitted how much he learned with his second child.

"Experts" have caused much consternation among parents by instructing that children must be kept forever happy. It has been a dictum that to keep children happy it is no longer sufficient to provide them with the skills needed to pursue happiness. Happiness must be ensured by the modern parent. Rosemond states that today's parents are nice folks and therein lies the problem. They let their children walk all over them because they do not feel they have the right to assertively disallow it. Parents have become disassertive.

Parenthood, especially with a first child, can be a tragedy of errors. There is no job so filled with responsibility which does not require proven knowledge and expertise. The

child is conceived, born and parented, in many cases, by totally untried incompetent individuals who rely on guidance by anyone willing to provide advice; be it good or bad. Maternal instinct is not enough. Of course there are some who have observed their parents actions, but what if they had been reared under the teachings of the experts who effectively provided the concepts of child rearing that are now increasingly being demonstrated to be without merit?

Now back to my initial question. Was I a good parent? I must face one fact . . . my parents were very strict, especially my father. "No" meant "no"; no questions to be asked. Now, children deserve to have a parent's position clarified, but not necessarily that a

**Parenthood,
especially with
a first child,
can be a
tragedy of
errors.**

child may challenge or disregard the parent's decisions. When faced with reality today, often children will complain that "no one ever said it was wrong". That is unfortunately a mistake.

I am satisfied with my actions as a parent. I (we) made mistakes; we made corrections. The best testimony I have to rely on was made by that first child. After being away to college some number of months and observing attitudes and behavior of other youngsters, she commented to me, "Thanks, Dad, for being tough at times. I now know why."

Can a Dad ask for any more than that? **IM**



MARION ALBERTS, MD

*A.M.: after marriage; three years in fact.

Dr. Lonnie Bristow Speaks To America's Patients About Medicare Reform:

I'm a practicing physician and I want my patients to know that Medicare will go broke by 2002 unless it's fixed now. The AMA has been working 10 years on ways to improve Medicare. Now Congress is about to act, and you need the straight story about what is really going on. Here are answers to questions patients ask me the most about the Medicare mess.

1. Does anyone have an answer?

The House Leadership has a plan that makes sense, tackles the hard financing problem and is good for patients. Most important, spending per person will *still* rise from \$4,800 to \$6,700 in 2002.

2. Will I have to give up what Medicare already gives me?

No. You can keep the security of traditional Medicare if you want. You won't have to do anything different.

3. Can I choose my own doctor and my own health plan?

Yes. In fact, patients will have more choices, including traditional Medicare, private insurance plans or a tax-free medical savings account.

4. How much more will it cost me?

You will pay a little more, but not a lot more. On average, monthly premiums will rise only \$6 a year over the next seven years. If you choose a private sector health plan, there may be expanded benefits and lower out-of-pocket expenses.

5. Will patients be protected?

Yes. Insurance plans can't discriminate against you for a pre-existing condition and you can appeal if the treatment your doctor recommends is denied.

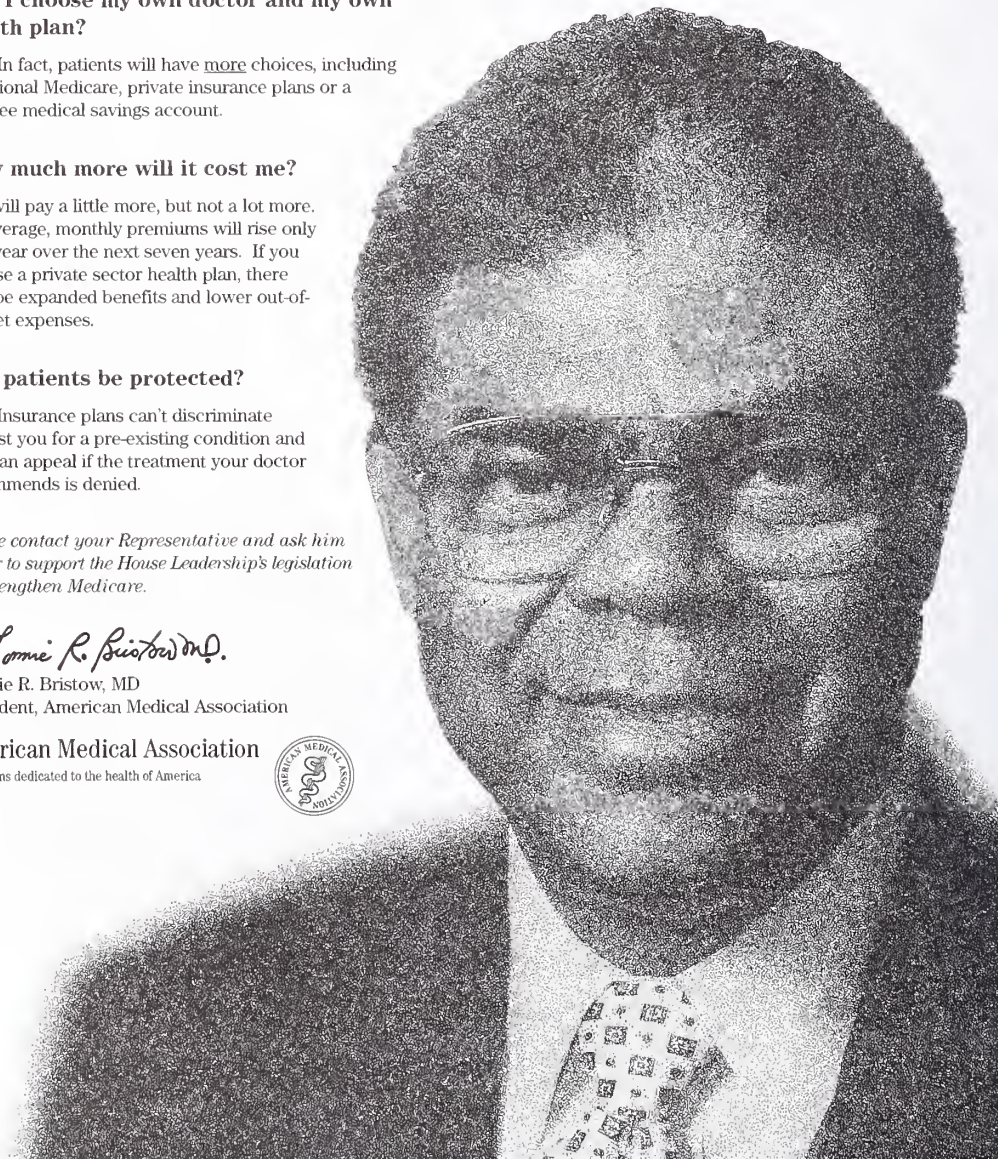
Please contact your Representative and ask him or her to support the House Leadership's legislation to strengthen Medicare.

Lonnie R. Bristow MD.

Lonnie R. Bristow, MD
President, American Medical Association

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Gullibility

The readily-quotable Sir William Osler remarked in an 1891 speech that “the desire to take medicine is perhaps the greatest feature which distinguishes man from animals,” a wry comment within his protest at public gullibility over patent medicines and advertising quacks. But being fond of people, he added “This is yet the childhood of the world, and a supine credulity is still the most charming characteristic of man.” Such gullibility may be charming, but its obverse, unfortunately, is mischief or danger.

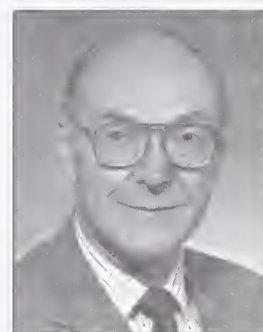
A related comment can be found in the delightful children’s book, *The Phantom Toll-booth* by Norton Juster, a “children’s book” like *Alice in Wonderland*, full of mature insight and satire. In it “Dr. Dischord” has made a diagnosis unsatisfactory to a character who protests that “There is no such illness as lack of noise.” “Of course not,” replies the doctor, “that’s what makes it so difficult to cure. I only treat illnesses that don’t exist: that way, if I can’t cure them, there’s no harm done—just one of the precautions of the trade.” Elsewhere, a character named the Mathemagician remarks, “You’ll find . . . that the only thing you can do easily is be wrong and that’s hardly worth the effort.”

It is probably because being wrong is so easy that many people succumb so readily to advertising. For example, in a medicine/phar-

macy section at the amazingly diverse, sprawling museum called the House on the Rock near Dodgeville, Wisconsin, you may view fascinating 19th century specimens of uninhibited claims: Tapeworms on sale for weight-control (“Easy to Swallow and Sanitary”); and nearby a bottle of Kickapoo Indian Cure for Tapeworm. See a bejeweled electric belt that will “Cure all that ails you”; or try a bottle of Methuselah Pills, with both subtle and brazen implications of a prolonged life span. There too in living color from mid-20th century is the display ad I remember clearly for Old Gold cigarettes: “The Proof is in the Smoking—Not a Cough in a Carload.” And much else.

Gullibility may be charming, but its obverse, unfortunately, is mischief or danger.

More than a century has passed since Osler made his comments. Were he here to assess contemporary American society, he would likely express pleasure and amazement at many advances, but he could hardly refrain also from assessing our world bleakly—with all its smugness about its literacy, advanced education and clear-headed sophistication. In fact, he might summarize the medical profession and the public using almost the same words he used in 1891. But he might no longer assess our “supine credulity” as “charming”. One of the great challenges of medical education and practice is to avoid gullibility in all its modern guises. **IM**



RICHARD CAPLAN, MD

Classified Advertising

General Surgeon BE/BC

The Department of Surgery at the Mayo Clinic, in conjunction with the Fairmont Clinic, is seeking 2 broad-based general surgeons to join a Mayo Regional Facility in Fairmont, Minnesota, 120 miles west of Rochester, Minnesota. This position offers an excellent opportunity to establish a surgical practice in an established 15-person Mayo-affiliated medical clinic in this town of about 11,000 with a 77-bed hospital and a service population of 45,000. This opportunity allows practice autonomy, a wide spectrum of general surgery, including some gynecological and orthopedic expertise and excellent salary and benefits. Inquires:

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Department of Surgery

Mayo Clinic

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ACUTE CARE, INC.

PO Box 515, Ankeny, IA 50021
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Fax 515/964-2777

Mankato Clinic, Ltd.—A progressive group practice is seeking additional BE/BC physicians in the following specialties: acute/urgent care, family practice, oncology/hematology, orthopedic surgery and general internal medicine practice. The Mankato Clinic is a 70-doctor multispecialty group practice in south central Minnesota with a trade area population of +250,000. Guaranteed salary first year, incentive thereafter with full range of benefits and liberal time off. For more information, call Roger Greenwald, Executive Vice President, at 507/389-8500 or Byron C. McGregor, Medical Director, at 507/389-8548 or write 1230 East Main Street, P.O. Box 8674, Mankato, Minnesota 56002-8674.

Assistant Residency Director, Department of Family Practice, University of Iowa College of Medicine—The Department of Family Practice at the University of Iowa College of Medicine is seeking an ABFP-certified physician to join the faculty as an Assistant Residency Director. Responsibilities include curricular design, procedural skills training and resident recruitment. The successful candidate will have practice experience and a minimum of one year teaching experience at the residency level and have competency in obstetrics. The department has a well-established 24-resident program that is university-administered, community-based and has admissions at community and university hospitals. The program is actively supported by both hospitals. A new model office facility is being built and expansion beyond the present one satellite rural office site is being pursued. As part of the full academic department, responsibilities include teaching, research and patient care. Academic appointment can be in either the traditional tenure track or a new clinical track. Scholarly activity is expected and supported. Appointment and salary commensurate with qualifications and experience. The University of Iowa is an Equal Opportunity/Affirmative Action Employer. Women and minorities are strongly encouraged to apply. Submit a letter of interest and CV to George R. Bergus, MD, Residency Director, Department of Family Practice, 2015 Steindler Building, Iowa City, Iowa 52242; 319/335-8456.

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Follow Your Instincts—Like the other 35 physicians in the family medicine department! They joined one of the nation's largest multispecialty groups for very good reasons: shared call coverage, strong specialty network and comprehensive salary/benefits. Enjoy autonomy, freedom from office management and protection from high insurance premiums. Opportunities are currently available in a variety of attractive Iowa and Wisconsin locations, including department chair of family medicine at the main clinic in Wisconsin. For more information, call Susan Pierce at 800/243-4353.

Emergency Medicine, Des Moines, Iowa—Opportunity to join an established emergency medicine practice at Iowa Lutheran, member of the Iowa Health System. BE/BC in emergency medicine or primary care specialty with experience. Call me to learn more about our department and generous compensation package. Contact Larry J. Baker, DO, FACEP, 700 E. University, Des Moines, Iowa 50316; 515/263-5263.

Family Physician—Family Medical Center is actively recruiting a BE/BC family physician to join 8 other family physicians and one general surgeon. Practice opportunity provides 1:9 call schedule, with full-time hospital ER coverage. Contract provides for attractive salary and excellent benefits. Send CV to Linda Cohrt, Office Manager, 1225 C Avenue East, Oskaloosa, Iowa 52577 or fax 515/672-2258.

LeMars

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Melissa J. Milliken, CMSC

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Family Practitioner—McFarland Clinic is actively recruiting a BE/BC family practice physician to assume the responsibilities of an established family medicine practice in central Iowa. Practitioner has support of over 80 medical and surgical sub-specialty physicians in same multispecialty group. Full privileges for a residency-trained family physician at Mary Greeley Medical Center, a 200-bed hospital in Ames, Iowa. Night call on a rotating basis at the Emergency Room at MGMC. McFarland Clinic offers distinct advantages for the practicing physician in providing excellent compensation and benefits, practice management services and a generous retirement program, all in an environment which emphasizes physician cooperation and teamwork. For additional information, call or submit CV to Karen Andersen, 515/239-4535, McFarland Clinic, P.C., 1215 Duff Avenue, Ames, Iowa 50010.

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Escape from the ordinary!—General surgeon needed to work in our thriving rural family practice. Candidate should have skills in C-section, gynecology and laparoscopic surgery. Eight weeks vacation/CME. Consultants available. Only group in county with 3 referral centers one hour away. Uniquely situated on I-94 half way between Madison and Twin Cities. Small town pride, excellent 51-bed hospital, great schools and recreation including all water sports, hunting, fishing, cross-country and downhill skiing. Cohesive group of caring physicians! Contact or send CV to Gary K. Petersen, Krohn Clinic, Ltd., 610 W. Adams St., Black River Falls, Wisconsin 54615; 715/284-4311.

Des Moines—IM, FP, PD needed to join growing elite practice! Above average salaries, good call coverage, excellent benefits. Call Mary Latter at 800/520-2028! Job #M141MJ.

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Rustic & Unique—Become a member of one of the largest multispecialty groups in the nation! This 300+ physician-owned group, based in southwest Wisconsin, is seeking an additional family physician for an established clinic in Iowa. Attractive practice offers shared coverage, modern local hospital, strong specialty network and comprehensive salary/benefit package. Friendly community surrounded by rolling hills, forest and trout streams. If you enjoy the ease and security of small-town living, with convenient access to metropolitan areas, call Susan Pierce at 800/243-4353.

Advertising Rates and Data

Regular classified advertising sells for \$2.00 per line with a \$30 minimum per insertion. For members of the Iowa Medical Society the rate is \$20 per insertion. Display classified advertising sells for \$25 per column inch, per month. Sizes range from 1 column by 2 inches to 1 column by 6 inches. A variety of type sizes, borders, reverses or screens can be included in the ad. Blind box numbers are available upon request at no additional charge. Copy deadline is the 1st of the month preceding publication. Send or fax copy to Iowa Medicine, 1001 Grand Avenue, West Des Moines, Iowa 50265-3599, fax 515/223-8420.

Director, Obstetrics and Gynecology—Broadlawns Medical Center, a 200+ bed county/community teaching hospital serving metropolitan Des Moines and Polk County, is seeking a well-rounded physician to direct the ob/gyn department. Activities will include supervising patient care teaching of family practice residents, a rotating ob/gyn resident and medical students in OB (500 births per year and growing). Department includes medical office clinical facilities, a Family Birthing Center with LDRP room accommodations; a Family Planning Program and mid-wife positions. Qualifications include an MD or DO degree, board certification or active candidacy of the American Board of Obstetrics and Gynecology, extensive practice experience and the ability to direct staff and programs to support the service and education goals of the facility. Clinical teaching experience is desirable. Post offer/pre-employment physical and drug screen required. This is a University of Iowa clinical appointment. Take the challenge and join our team! If interested contact D.J. Walter, MD, 1801 Hickman Road, Des Moines, Iowa 50314; 515/282-2203. Minorities and women encouraged to apply. Broadlawns is an Equal Opportunity/Affirmative Action Employer.

Clarkson Family Medicine—Clarkson Family Medicine opened its doors July 1, 1991. We have filled in the Match Program every year since then and have expanded from a 12-resident program to an 18-resident program in 1995. We have seen our graduates, as a group, score in the top 10% nationally on the in-training exam. We currently have 4 full-time family practice faculty, one obstetrician, one pediatrician and full-time behavioral science coverage, including 2 part-time psychiatrists. In order to provide the training necessary to prepare our residents for rural practice, including extensive OB and procedural experience, we are recruiting 2 additional family physician faculty. Requirements include practice and/or teaching experience, strong OB background and a desire to participate in a new, exciting and growing residency program. Responsibilities and salary are negotiable and based on experience. Clarkson Hospital takes pride in being a smoke-free environment and does not hire applicants who use tobacco products. EOE. Send CV and/or letter of inquiry to Richard A. Raymond, MD, Director, Clarkson Family Medicine, 4200 Douglas Street, Omaha, Nebraska 68131; 402/552-2045.

Conrad, Iowa—Marshalltown Medical & Surgical Center seeks board certified physician or recent graduate of an accredited residency program for a partnership opportunity in Conrad, Iowa. An exceptional rural community, Conrad is located in central Iowa, only 60 minutes north of Des Moines. A progressive, civic-minded town, Conrad has an active Main Street Program, healthy retail sector, quality public schools and many amenities which you would expect to find in a larger community. Residents recently surpassed a \$150,000 fund drive to build a new water park complex. Clinic staff includes two full-time physicians and two part-time physician assistants. The 2,500 square foot facility houses up-to-date laboratory and x-ray equipment, as well as computerized billing and appointment scheduling capabilities. You will earn competitive salary/benefits, paid interview/relocation expenses and an option for a forgivable loan. For more information contact Shelley Shiflett, Marshalltown Medical & Surgical Center, 800/542-0014 or send or fax resume to 3 South 4th Avenue, Marshalltown, Iowa 50158; fax 515/754-5181.

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Call collect to administrator:

Curt Nielsen

Brainerd Medical Center, P.A.

218/828-7105 or 218/829-4901

2024 South 6th Street, Brainerd, Minnesota 56401

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Franciscan Skemp Healthcare

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Contact:

Tim Skinner, M.S.Ed., or Bonnie Nulf
Franciscan Skemp Healthcare
800 West Avenue South
La Crosse, WI 54601
Phone: (800) 269-1986
Fax: (608) 791-9898

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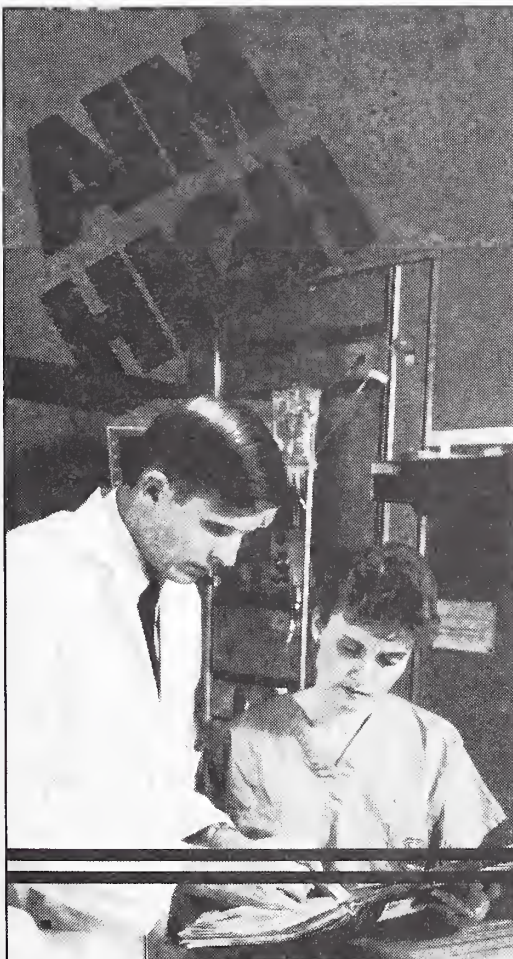
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Allergy Institute, PC
A.Y. Al-Shash, MD
R.K. Agarwal, MD

1701 22nd Street, Suite 201
West Des Moines 50266
515/223-8622

Pediatric and Adult Allergy, PC
Veljko K. Zivkovich, MD
Robert A. Colman, MD

1212 Pleasant, Suite 110
Des Moines 50309
515/544-7229

Asthma, Allergy & Immunology

Dermatology

Robert J. Barry, MD

1030 Fifth Avenue, SE
Cedar Rapids 52403
319/366-7541

*Practice Limited to Disease,
Cancer and Surgery of Skin*

Fort Dodge Medical Center, PC
Carey A. Bligard, MD, FAAD
James D. Bunker, MD, FAAD

804 Kenyon Road
Fort Dodge 50501
515/574-6850

Electrodiagnosis

John Milner-Brage, MD

208 St. Francis Professional Building
Waterloo 50702
319/234-6446

*Electromyography & Nerve
Conduction Studies
Certified by American Board of
Electrodiagnostic Medicine*

Emergency Medicine

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Ankeny 50021
515/964-2772 or 1-800/729-7813

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Practice, Locum Tenens,
Doctor on Call*

Emergency Practice Associates

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Waterloo 50704
1-800/458-5003

*Specialists in Emergency
Staffing & Emergency Department Services*

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515/964-2772 or 1-800/729-7813

*Locum Tenens
Doctor on Call*

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Associates, PC**
Daniel H. Gervich, MD
Daniel J. Schroeder, MD
Ravi K. Vemuri, MD
Infectious Diseases

1601 NW 114th, Suite 347
Des Moines 50325-7072
24 Hours 515/224-1777

Infertility

Mid-Iowa Fertility, PC
Donald C. Young, DO

3408 Woodland Avenue, Suite 302
West Des Moines 50266
515/222-3060

*Reproductive Endocrinology/Infertility
IVF and GIFT Procedures
Donor Oocyte Program
Artificial Inseminations
Reproductive Surgery
Menopause Management*

Internal Medicine

Fort Dodge Medical Center, PC
Cardiology
Samir G. Artoul, MD, FICC

515/574-6840

Gastroenterology
Kenneth W. Adams, DO, AOBIM
General Internal Medicine
William C. Robb, MD
Richard H. Brandt, MD, ABIM
Grace Z. Ang, MD

800 Kenyon Road
Fort Dodge 50501
515/574-6820

Neurology

Iowa Medical Clinic Neurology
Andrew C. Peterson, MD
Laurence S. Krain, MD

600 7th Street SE
Cedar Rapids 52401
319/398-1721

*Neurology, EEG, EMG, Evoked Potentials
and Sleep Studies*

Fort Dodge Medical Center, PC
Jugal T. Raval, MD, MBBS

800 Kenyon Road
Fort Dodge 50501
515/574-6845

Neurosurgery

Iowa Medical Clinic
Neurosurgery
James R. Lamorgese, MD
Loren J. Mouw, MD

600 7th Street, SE
Cedar Rapids 52401
319/366-0481

Practice limited to Neurosurgery

Hosung Chung, MD

2710 St. Francis Drive, Suite 401
Waterloo 50702
319/232-8756; fax 319/232-5703

Practice limited to Neurosurgery

Neurosurgical Services LLP

Robert Hayne, MD

Thomas A. Carlstrom, MD

David J. Boarini, MD

1215 Pleasant, Suite 608

Des Moines 50309

515/241-5760

Robert C. Jones, MD

S. Randy Winston, MD

Douglas R. Koontz, MD

2600 Grand Avenue, Suite 210

Des Moines 50312

515/283-2217

Neurological Surgery

Chad D. Abernathey, MD

1953 1st Avenue SE

Cedar Rapids 52402

319/363-4622

Neurological Surgery

Obstetrics/Gynecology

Fort Dodge Medical Center, PC

Brian L. Welch, MD

800 Kenyon Road

Fort Dodge 50501

515/574-6870

Ophthalmology

Wolfe Clinic, PC

Russell H. Watt, MD

John M. Graether, MD

Gilbert W. Harris, MD

James A. Davison, MD

Norman F. Woodlief, MD

Eric W. Bligard, MD

David D. Saggau, MD

Steven C. Johnson, MD

Todd W. Gothard, MD

309 East Church

Marshalltown 50158

515/754-6200

Satellite Offices

Lakeview Medical Park

6000 University Avenue, Suite 300

West Des Moines 50266

515/223-8685

804 South Kenyon Road, Suite 100

Fort Dodge 50501

515/576-7777

Sartori Professional Building

516 South Division Street

Cedar Falls 50613

319/277-0103

214 - 13th Street Southeast

Cedar Rapids 52403

319/362-8032

Ophthalmic Associates, PC

Robert D. Whinery, MD

Stephen H. Wolkstein, MD

Robert B. Goffstein, MD

Lyse S. Strnad, MD

John F. Stamler, MD, PhD

540 E. Jefferson, Suite 201

Iowa City 52245

319/338-3623

North Iowa Eye Clinic, PC

Addison W. Brown, Jr., MD

Michael L. Long, MD

Bradley L. Isaak, MD

Randall S. Brenton, MD

James L. Dummett, MD

Mick E. Vanden Bosch, MD

3121 4th Street, S.W.

P.O. Box 1877

Mason City 50401

515/423-8861

Timothy F. Moran, Jr., MD

United Federal Building

700 4th Street, Suite 305

Sioux City 51101

712/252-4333

Satellite Clinics

Horn Memorial Hospital

700 E. 2nd Street

Ida Grove 51445

712/364-3311

Orange City Hospital

400 Central Avenue NW

Orange City 51041

712/737-2426

General Ophthalmology

Orthopaedics

Iowa Orthopaedic Center, PC

Marshall Flapan, MD

Sinesio Misol, MD

Joshua D. Kimelman, DO

Timothy G. Kenney, MD

Lynn M. Lindaman, MD

Jeffrey M. Farber, MD

Kyle S. Galles, MD

Scott A. Meyer, MD

Cassim M. Igram, MD

Rodney E. Johnson, MD

Martin S. Rosenfeld, DO

Teri S. Formanek, MD

Stephen M. Naruto, MD

Donna J. Bahls, MD

Jill R. Meilahn, DO

Jacqueline M. Stoken, DO

411 Laurel, Suite 3300

Des Moines 50314

515/247-8400

Orthopaedic Surgery

Fort Dodge Medical Center, PC

C. Mark Raec, MD

Emile C. Li, MD

800 Kenyon Road

Fort Dodge 50501

515/574-6880

Otolaryngology

Iowa ENT, PC

Thomas A. Eriksen, MD

Marshall C. Greiman, MD

Steven R. Herwig, DO

Thomas O. Paulson, MD

Mark K. Zlab, MD

1-800/248-4443

1215 Pleasant, Suite 408

Des Moines 50309

515/241-5780

1200 35th Street, Suite 200

West Des Moines 50266

515/225-7761

Satellite Clinics:

Pella, Perry, Newton, Indianola,

Oskaloosa, Guthrie Center, Knoxville

Wolfe Clinic, PC

Michael W. Hill, MD

Daniel J. Blum, MD

309 East Church

Marshalltown 50158

515/752-1566

Lakeview Medical Park

6000 University Avenue, Suite 310

West Des Moines 50266

515/224-9533

Sartori Professional Building

516 South Division Street

Cedar Falls 50613

319/277-3105

Otolaryngology-Head and Neck Surgery,

Facial Plastic Surgery, Allergy

(Continued next page)

Professional Listing Rates

Physician members of the Iowa Medical Society may advertise in this directory. Monthly rates are as follows: \$10.00 first 3 lines; \$2.00 each additional line. Billed yearly. May be prorated. Send or fax copy to Iowa Medical Society, 1001 Grand Avenue, West Des Moines, Iowa 50265-3599, fax 515/223-8420.

Iowa Head and Neck Associates, PC

Robert T. Brown, MD
Eugene Peterson, MD
Richard B. Merrick, MD
Peter V. Boesen, MD
Robert R. Updegraff, MD
 3901 Ingersoll
 Des Moines 50312
 515/274-9135

Dubuque Otolaryngology-Head & Neck Surgery, PC

Thomas J. Benda, Sr., MD
James W. White, MD
Craig C. Herther, MD
Thomas J. Benda, Jr., MD
 310 North Grandview Avenue
 Dubuque 52001
 319/588-0506

Otologic Medical Services, PC

Roger A. Simpson, MD
Guy E. McFarland, MD
Thomas F. Vincer, MD
Douglas E. Dawson, MD
 540 E. Jefferson, Suite 401
 Iowa City 52245
 319/351-5680
 1-800/642-6217

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1040 5th Avenue
 Des Moines 50314
 515/244-8152
 1-800/622-0002

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1000 Illinois
 Des Moines 50314
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Neurosurgeon, Medical Director
Sandra Gannon, LSW, ACSW, Program Director
 600 7th Street SE
 Cedar Rapids 52401
 319/399-2013
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Pediatrics

Fort Dodge Medical Center, PC
Ronald C. Sanders, MD
Rosana M. Diokno, MD
 800 Kenyon Road
 Fort Dodge 50501
 515/574-6855

Perinatology

Des Moines Perinatal Center, PC
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 319/383-1466

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Fareeduddin Ahmed, MD
Arthur B. Searle, MD
Bogdan E. Krysztofiak, MD

Rehabilitation Medicine Associates

William D. deGravelles, Jr., MD
Charles F. Denhart, MD
Marvin M. Hurd, MD
William C. Koenig, Jr., MD
Karen Kienker, MD
Todd C. Troll, MD
Lori A. Sapp, MD

Yunker Rehabilitation Center
Iowa Methodist Medical Center
 1200 Pleasant
 Des Moines 50308
 515/241-6434

2600 Grand Avenue, Suite 102
 Des Moines 50312
 515/283-1570

Pulmonary Medicine

Fort Dodge Medical Center, PC
Robert C. Ang, MD, FCCP
 800 Kenyon Road
 Fort Dodge 50501
 515/574-6820

Chest, Infectious Diseases & Critical Care Associates, PC

Roger T. Liu, MD
Steven G. Berry, MD
Donald L. Burrows, MD
Michael Witte, DO
Gerard A. Matysik, DO
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 800 Kenyon Road
 Fort Dodge 50501
 515/574-6865

Vascular Surgery**Fort Dodge Medical Center, PC**

Marshall C. Hunting, MD
 800 Kenyon Road
 Fort Dodge 50501
 515/574-6865

Urology**Fort Dodge Medical Center, PC**

Steven P. Hoff, MD
 800 Kenyon Road
 Fort Dodge 50501
 515/573-4141

AMA's role in the Medicare reform bill

At the recent North Central Medical Conference meeting, I had the opportunity to hear AMA President Lonnie Bristow deliver a few comments on a variety of subjects, primarily Medicare reform and the AMA Board of Trustees.

I was especially interested in the AMA's role in development of the Medicare reform bill. Last January, Newt Gingrich invited AMA leaders and other health care organization leaders to a meeting. He asked them to return in two weeks with their ideas and "to be bold". As many of you know, the AMA had been working on a plan for some time and was ready for this opportunity. About 80% of the AMA plan was adopted. Many of you are also familiar with the bill's provision for liability limitation of \$250,000 for non-economic loss. This particular provision also guarantees that most of the dollars will go to the patients rather than trial lawyers. There is regulatory relief from Stark I and II and from CLIA. Patient protection is also addressed with regard to managed care plans and guarantees

that patients be informed as to rights and responsibilities. There is also encouragement for physician-sponsored networks to compete with insurance companies and other health care networks.

What about the "deal" the AMA supposedly made with the GOP leadership regarding the Medicare conversion factor? Physicians account for approximately 23% of Medicare

Part B expenditures. However, over the last 13 years we have been the recipients of 32% of the cuts in this area. The average overhead for a physician is 50% and the proposed conversion factor would set Medicare payments at only 10-20% above that. This small margin could result in a lack of access for Medicare patients. As Dr. Bristow said, "They listened and agreed to attempt to increase the conversion factor." The conversion factor was increased from \$34.60 to \$35.42. This doesn't seem like a great deal. However, when coupled with the new formula for volume growth, over the next seven years this is projected to add up to \$20 billion more than under current law. That was the "deal" that the press made so much of. It is a good example of the AMA advocacy for physicians and patients.

Over the next seven years this amounts to \$20 billion more than under current law.

Dr. Bristow also made another important point. The AMA has limited its proposals and involvement to Medicare and properly did not become involved in the debate over the tax cut. This is a separate issue; the AMA is bipartisan.

I had the opportunity to visit with Dr. Bristow one evening. He is an engaging, articulate, warm and friendly man. I asked him what he does in his spare time (as if he had any). He hesitated slightly and then said when he has the time (on the road I assume) he often visits an inner city school and talks with the children. He is my kind of guy. I am pleased that he is our president. **IM**



JOSEPH HALL, MD

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Farewell to a friend

Tina Preftakes joined the staff of the Iowa Medical Society in June of 1952, fresh from the University of Iowa with a degree in journalism. Her original salary card lists her job as "See — tv". Translated, it was Tina's responsibility to produce a live television show featuring real doctors in real practice situations.

It is speculated that this experience gave Tina the nerves of steel in the face of calamity which she retained throughout her years at the IMS. As time went on, she progressed upward through various positions and titles — administrative assistant, executive assistant, assistant director and, finally, assistant executive vice president. This list is incomplete; the important thing to know is that Tina accomplished whatever was asked of her with the utmost efficiency and unfailing good humor.

When people who have worked closely with Tina are asked to describe her, they invariably mention the fact that the IMS has been such a big part of her life. They talk about her loyalty to Iowa physicians and the difference she made for so many of them.

"The efficiency and quality of staff support Tina provided excelled over all the others," says Dr. Paul Seebom, associate dean with the


UI College of Medicine and past IMS president. "No one is better at anticipating problems and tending to details than Tina."

"Tina could always see the big picture. Her professionalism and dedication have truly benefited Iowa physicians," comments Dr. Hormoz Rassekh. Dr. Rassekh, a Council Bluffs psychiatrist, is also a past IMS president and one of the many Iowa physicians Tina counts among her lengthy list of friends.

IMS staff members — who think of Tina as much more than a co-worker — say she is the most giving person they know. They praise her perpetual willingness to go the extra mile for IMS members and for her friends.

Even more significant, all her co-workers have learned much from the example Tina has set, day in and day out, for 43 years. Through Tina, we saw the importance of respecting everyone's opinions and feelings.

As we bid Tina farewell, we hope that once in awhile we will still hear her ready laugh and those wonderful stories about her childhood in Clarion. We hope that occasionally we might get one of those silly notes signed with her own "TP" logo.

Tina, we wish you a happy and productive retirement. See you back at the ranch. 



IMS Update

AT A GLANCE

The harmful effects of alcohol, tobacco and other drugs on unborn babies is the topic of a new 11-minute video available from the Iowa Substance Abuse Information Center. The video was filmed in Iowa and is ideal for physicians' reception areas. To order a complimentary copy, call 800/247-0614.

The Iowa Distance Learning Association's third annual conference is planned for February 29 through March 1, 1996 at the University of Iowa Memorial Union. Telemedicine and video-conferencing will be on the agenda. For further information on how to register, call 515/271-2182.

There has been a sharp increase in use of methamphetamines by Iowans. Of those seeking treatment at substance abuse centers, 7.3% listed meth as their primary problem, compared to 2.2% the year before.

MARK YOUR CALENDARS

Mark your calendars now for the 1996 IMS Annual House of Delegates and Scientific Session

**Friday—Sunday, April 19—21
Embassy Suites • Des Moines**

IMS offices up for election in 1996

Offices up for election at the Iowa Medical Society's 1996 Annual Meeting April 20-21 include: (The length of each term is in parenthesis, along with the name of the physician now holding the office.)

PRESIDENT ELECT (1) — William McMillan, MD
VICE PRESIDENT (1) — Sterling Laaveg, MD
TRUSTEE (3) — Harold Miller, MD
HOUSE SPEAKER (1) — Donald Kahle, MD
VICE SPEAKER (1) — Tom Throckmorton, MD
AMA DELEGATES (2) — Clarence Denser, Jr., MD; Donald Young, MD; Bruce Trimble, MD
AMA ALTERNATES (2) — Thomas Graham, MD

Judicial Councilors are elected by a district wide vote of eligible IMS voting members. The names of physicians elected as Judicial Councilors will be submitted for confirmation by the 1996 House of Delegates. Details will be sent to county medical societies due to elect councilors in 1996.

Up for election are:

DISTRICT 2 — Jamal Hoballah, MD
DISTRICT 4 — Albert Coates, MD
DISTRICT 5 — Ross Madden, MD
DISTRICT 10 — Michael Disbro, MD
DISTRICT 11 — C. David Smith, MD
DISTRICT 14 — Stephen Richards, DO

The IMS Program Committee has been making plans for the 1996 Scientific Session,

which will begin on Friday, April 19 at the Embassy Suites, in conjunction with the House of Delegates.

Tentative topics for the Scientific Session include: Grave's Disease, genetic engineering in cystic fibrosis, vascular disease in the elderly and youth violence.

IMS Board meets with CHMIS committee

The IMS Board of Trustees met recently with the CHMIS Executive Committee. Read details of the discussion (and important information on signing a contract with a CHMIS network) on page 476 of this issue. **IM**

SPECIALTY SOCIETY UPDATE

The Iowa Association of County Medical Examiners met Friday, November 3 at the Sheraton Inn in Cedar Rapids. Dr. R.C. Wooters, retired Polk County Medical Examiner, was honored by Governor Terry Branstad at the group's luncheon.

The Iowa Oncology Society annual fall membership meeting was held at the McFarland Clinic in Ames Friday, October 27. Dr. Joseph Bailes of the American Society of Clinical Oncology was guest speaker. New oncology practice arrangements and Medicare reform were also discussed.

A record number of members attended the Iowa Psychiatric Society annual meeting October 27-28 in Iowa City. The role of serotonin in psychiatric illness was part of an excellent program planned by Brian Cook, DO. Terrence Augspurger, MD was nominated as IPS president. A committee plans to meet December 6 with Merit Behavioral Health Corporation (formerly Medco) regarding continuing concerns. Committee members are: Michael Egger, MD; Loren Olson, MD; James Pullen, MD; S. Ravapati, MD; Tom Garside, MD; and Cindy Hoover, MD.

The Iowa Medical Group Management Association continues developing a uniform credentialing form for physicians applying for participation with insurance companies, hospital privileges or licensing. A meeting of organizations interested in this project was scheduled for November 28.

Futures

Iowa Health Reform Transition Team

The Iowa Health Reform Transition Team held its final meeting October 26. The team has worked for the past three years to guide and advise state policy and lawmakers on health reform options and initiatives in Iowa.

David Lyons is chairman of the team; William Eversmann, MD represented IMS. Much of the team's work has been funded by the Robert Wood Johnson Foundation.

It is hoped Iowa will win another RWJ grant to undertake additional initiatives in the future.

Attention: physician entrepreneurs

Physician Entrepreneurship: Principles, Practices and Tactics for Business Plan Development is the focus of a program to be held January 8-10 on the Northwestern University Campus.

Presented in conjunction with Northwestern's Kellogg Graduate School of Management, the intensive three-day program highlights how to develop an effective business plan, how to raise capital, entrepreneurial finance and keys to developing strategic alliances. The cost of the program (including all meals, housing, registration and course materials) is \$2,000 for AMA members; \$3,000 for nonmembers.

For more information or to register, call Katherine Rouse at 312/464-4274.

AMA president meets with senior citizens

Lonnie Bristow, MD, AMA president, met recently with 800 senior citizens in a California retirement community and urged them to support the GOP's Medicare reform package. Dr. Bristow said the package is an opportunity for retirees to protect their children.

Meanwhile, lobbyists for the elderly, the disabled and all sorts of health providers

were converging on Capitol Hill as the full Senate geared up for a vote on Medicare reform. As of press time, Republican leaders were working to overcome GOP divisions caused by changes needed to win Senate approval for the Medicare proposal.

There was speculation the president will veto any bill the GOP sends him, so GOP leaders asked him to come to the bargaining table. Clinton refused and told Republicans once again to back off cuts in vital areas like Medicare. Republicans reportedly lack the votes to overcome a presidential veto.


The Senate Finance Committee amended its Medicare reform proposal to allow physician and hospital networks to contract directly with the program, putting the Senate Republican proposal more in line with the House version, which would ease regulations that hinder development of such networks.

Medical Records Confidentiality Act

Three US senators have introduced the Medical Records Confidentiality Act, which would govern the use of medical treatment and payment records in written and electronic form. The measure would insure that patients have the right to inspect their health records while safeguarding personal data to keep the information from getting into the wrong hands.

In Iowa, the CHMIS Governing Board has said that patient-specific information will never be released from the CHMIS. There reportedly has been no discussion of this federal proposal by the CHMIS Board.

HMO's have 'spillover' effect

Increased enrollment in Medicare HMOs means decreased costs, not only through managed care savings, but through a 'spillover' effect that lowers Medicare fee-for-service costs, according to a study by the HMO trade group, GHAA. 

AT A GLANCE

According to a recent study reported in JAMA, more than one-third of Americans under age 65 are uninsured or lack adequate coverage.

Under a block grant scenario, states will be free to scrap existing Medicaid programs in favor of managed care. Already, 49 states are poised to launch or expand such programs. If Congress succeeds in cutting Medicaid by \$182 billion, states will face a difficult choice — allocate more money to Medicaid or cut benefits. Some experts are predicting widespread hikes in state taxes in the future. Iowa Medicaid staff are studying options in order to be ready once federal decisions are made.



CHMIS Update

This CHMIS Update is a regular feature in *Iowa Medicine*, and is part of the Iowa Medical Society's effort to keep you informed about CHMIS.

YOUR representatives on state CHMIS committees:

CHMIS Governing Board:

Dale Andringa, MD
Des Moines
515/241-4102

Beth Bruening, MD
Sioux City
712/233-1529

CHMIS advisory committees:

Communications/Education

Laine Dvorak, MD
Clarence Denser, Jr., MD

Data Advisory

John Brinkman, MD

Ethics/Confidentiality

Charles Jons, MD

Quality Review

Elie Saikaly, MD
William Langley, MD

Technical Advisory

Mark Purtle, MD

IMS CHMIS Committee:

Terrence Briggs, MD (chair)

IMS staff:
Ed Whitver
Barb Cannon Heck
Dean Gillaspay

The IMS Board of Trustees met with the CHMIS Executive Committee on October 18. The Board and the Committee discussed the following issues of importance to Iowa physicians:

1. Electronic insurance eligibility verification will begin July 1, but it is uncertain what will be included in the initial system. Eligibility can encompass many features. A work group of providers and payers is defining minimum elements to include in an eligibility system on July 1, as well as future expansion, while attempting to balance cost to benefits.

2. ERISA plans (self-administered health plans) are not obligated to participate in CHMIS since they are governed by federal law. They have been encouraged to participate voluntarily.

3. The data repository contractor will have only six months to install hardware and software, hire employees and test the system between providers, payers, net-

works, etc. This short start up time frame is a concern to members of the CHMIS Governing Board, who now say July 1 is a starting point for CHMIS implementation.

4. The cost of CHMIS remains an elusive topic. Much depends on the cost to operate the data repository, which will not be clear until the contract is awarded this month. The IMS maintains the position that CHMIS should reduce administrative costs for physicians and that cost should not be borne disproportionately by providers.

5. Data confidentiality will be a key concern to physicians as long as the CHMIS exists. The IMS Board of Trustees questioned CHMIS representatives at length regarding patient confidentiality issues.

6. Other provider groups will probably begin CHMIS participation by July, 1997. CHMIS representatives said it is desirable for everyone to gain experience and improve the process before other providers are brought in.

At the October CHMIS Governing Board meeting, it was announced that 19 entities attended the data repository bidders conference. Bids are due November 15.

Important news about CHMIS networks . . .

PHYSICIANS ARE ADVISED NOT TO SIGN A CONTRACT WITH A CHMIS NETWORK UNLESS THE CONTRACT HAS AN ESCAPE CLAUSE

Criteria for certification of CHMIS networks are now complete and potential network vendors are beginning the process of earning CHMIS certification. The process of earning final, unconditional CHMIS certification will take a year or longer. As a result, there will be no fully-certified networks by July 1, the deadline date for CHMIS implementation.

However, members of the CHMIS Governing Board say some networks will be granted "provisional" certification in time for the July 1 deadline. Companies who have applied for full CHMIS certification (and have been granted "provisional" status) could begin marketing campaigns to Iowa physicians as early as January or February of 1996. This means that if a physician signs with a "provisional" network and that network does not ultimately receive full certification, the physician will be forced to find a new network.

Consequently, physicians should make sure there is an 'immediate termination' clause in any contract signed with a "provisional network".

Watch the February issue of *Iowa Medicine* for guidelines on selecting a network.

For more information about CHMIS networks, call Ed Whitver of the IMS staff, 515/223-1401 or 800/747-3070.

Legislative Affairs

Pensions and malpractice lawsuits

Under current Iowa law, pensions (except IRAs) are exempt from tort claimant creditors, according to a recent legal opinion prepared at the request of the IMS.

Iowa law provides for the exemption from execution by creditors of the cash surrender value of life insurance; a benefit or indemnity paid under an accident, health or disability insurance policy; social security benefits; unemployment compensation; veteran's benefits; alimony maintenance or support and pensions; and annuities or similar contracts triggered by illness, disability, death, age or length of service.

Accrued dividends, cash surrender value or interest in a life insurance policy is also exempt if the beneficiary is the person's spouse, child or dependent.

A payment or portion of a payment under a pension, annuity or similar plan or contract on account of illness, disability, death, age or length of service is exempt, unless the payment results from contributions to the plan within one year prior to the filing of a bankruptcy petition.

Physicians are cautioned that independent and individualized analysis is necessary to

determine the exempt status of any individual's assets.

For a copy of the complete legal opinion on exemption of pensions from tort creditors, call Chris McMahon at the IMS, 515/223-1401 or 800/747-3070.

Legislature convenes January 8

January 8 is the opening day of the 1996 legislative session. While major health issues are not likely to be at the top of the agenda, there are always plenty of issues that arise to keep IMS lobbyists busy.

The IMS is continuing to work with senators to encourage their support of HIF 394, the IMS statute of limitations for minors bill which passed the House in 1995.

Legislators have been requested to draft bills relating to insurance coverage for obstetrical care and patient access to medical records.

IMS Council discusses OB stay

At its September meeting, the IMS Executive Council adopted the following position which addresses the trend toward reduced coverage for hospital stays following

continued

AT A GLANCE

The FDA will propose rules to ban distribution through vending machines (except in bars) and stop tobacco company sponsorship of sporting events and concerts. Until the issue of whether FDA has a right to regulate tobacco is settled, court battles will continue.

According to Modern Healthcare, during the last election cycle the American Medical Association was the most balanced with regard to political contributions. From January of 1993 to November 1994, 58% of the AMA's political action funds went to Republicans; 42% went to Democrats. The American Hospital Association split was 65% for Democrats and 35% for Republicans. Other organizations named — including associations representing optometrists and nurses — contributed nearly 75% of their PAC funds to Democrats.

IMS STAFF 'ON THE ROAD' MEETING WITH MEMBER PHYSICIANS

An IMS staff "road show", which includes a videotape presentation on the IMS 1996 legislative priorities, is available to Iowa physicians who want information on the Iowa Medical Society's priorities for the coming year in several areas. The tape is about 20 minutes long. On the video, physicians involved in the IMS legislative program discuss the IMS priorities and the impact of grass roots involvement in the political process.

As scheduling permits, Paul Bishop, IMS legislative liaison, will be on hand to answer questions after the tape is shown. Ed Whitver, manager of health care data and information, and Tom Leners, a representative of Midwest Medical Insurance Company, will also be on hand to answer questions about CHMIS, data collection efforts and the liability insurance market.

To borrow a videotape or to arrange for a program in your area, call Paul Bishop at the IMS, 515/223-1401 or 800/747-3070.

Legislative Affairs

continued

the birth of a baby:

IMS believes the decision on length of hospital stay following the birth of a baby should be decided by the physician and patient based on the needs of the mother and baby.

The IMS should attempt to work with key organizations on this issue, including third party payers, employer organizations and other provider groups.

The Council left open whether or not to support legislation on this subject pending discussions with payers. Concerns were voiced by many Council members about the undesirable precedent of legislating length of hospital stay. The situation will be evaluated once the legislative session has begun.

Taxes will be an issue, too

Taxes are expected to be a big item for legislators as they consider whether to provide tax relief for Iowans, spend revenue surpluses on needed infrastructure improvements or wait to see what impact possible federal changes in Medicaid and welfare programs have on Iowa.

Rural health grants announced

A dozen Iowa communities will be receiving financial help to recruit medical professionals, according to information from the Iowa Department of Public Health.

The grants will go to 12 facilities and will be used for everything from purchase of equipment, health assessments, connections to the fiber optic network and recruitment of medical professionals. The 12 communities were chosen from 33 applicants. Eleven grants are for \$10,000; one is for \$30,000.

Recipients are:

Van Buren County Hospital, Keosauqua
City of Fonda

City of Lake Park

Massena Industrial Development Corp.

Sloan Community Development Council

Merey Hospital, Corning

Staeyville Community Nursing Home

Lucas County Memorial Hospital

St. Mary's, Dyersville

Kossuth Regional Health Center, Algona

City of Maxwell

Pella Community Hospital **IM**



***The Iowa Medical Society Alliance
Board of Directors and past IMSA
presidents extend best wishes to you
and your family for a happy holiday season!***



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Pam & Bob Smits
Sharon & Allan Swanson

Medical Economics

Managed Substance Abuse Care Plan

The Iowa Department of Human Services recently sent a detailed letter to Iowa physicians regarding the Iowa Managed Substance Abuse Care Plan (IMSACP).

The letter discusses evaluations, eligibility, referral and billing for Medicaid patients receiving substance abuse services.

The informational release was written primarily for health care providers who are not under contract with IMSACP. Any physician who has a question about the program may call the IMSACP provider hotline, 800/836-8619, during business hours.

The IMS has a copy of the IMSACP informational release. If you would like one, call Sherry Johnson at the IMS, 800/747-3070 or 515/223-1401.

AMA: Don't dilute CLIA reform

The American Medical Association and 16 medical specialty societies were successful in convincing Congressman Thomas Coburn, MD (R-OK) to abandon efforts to offer a draft amendment on CLIA in the House Ways and Means mark-up on Medicare.

In a strongly worded letter, the AMA urged Congressman Coburn not to offer his amendment, which would have narrowed the CLIA reform legislation contained in the House leadership Medicare reform package, exempting only labs which "meet requirements of a recognized quality assurance program for laboratory services".

According to a recent backgrounder piece from the Heritage Foundation, physician labs are "caught in a web of government red tape" that adds billions of dollars to America's health care costs. The Heritage Foundation supports CLIA reform in the context of Medicare reform.

"This misguided regulatory intervention is based on faulty data, has caused the loss of private laboratory testing and has compro-

mised patient access to high quality care," says the informational release.

According to Heritage, CLIA implementation adds between \$1.2 billion and \$2.1 billion annually to the cost of performing clinical lab tests in doctors' offices.

HCFA officials failed to account for the following cost factors brought about by CLIA:

- Abrupt changes in practice patterns.
- The cost of return visits to have test results previously available at the time of the initial visit explained and a treatment regimen advanced.
- Unnecessary hospitalizations and emergency room visits when a physician cannot perform certain tests in the office due to excessive regulatory costs.
- Increased morbidity and complication rates from diagnostic delays in notifying patients of serious problems.

Fortunately, CLIA's regulatory burdens on doctors and the impact on patients have attracted attention in both the House and Senate. In the House, Bill Archer and dozens of his colleagues are leading the effort to reintroduce sense and sanity to the issue. Kay Bailey Hutchison and colleagues are sponsoring a similar bill in the Senate.

Any physician who would like copies of the Heritage Foundation backgrounder on CLIA may call Chris McMahon or Bev Corron at the IMS, 800/747-3070 or 515/223-1401. The piece focuses on the roots of CLIA, CLIA's impact on medical practice and the high cost of regulating without scientific consensus.

Medicalization of social problems

The "medicalization" of social problems accounts for over one third of America's health care costs, according to Leroy Schwartz, MD, president of Health Policy International (HPI).

The US has the highest rates of unsafe sex,

AT A GLANCE

Druggists in growing numbers are refusing to sell tobacco products. In California, they say that cigarette sales violate their commitment to public health; the AMA has urged local medical societies to encourage such actions. Meanwhile, the Canadian Supreme Court has struck down the ban on tobacco advertising, saying it violates free expression.

Though there's lots of talk about big savings that can be accomplished by rooting out waste and fraud and sharing the money with whistle-blowers, the savings won't even match the \$15 billion growth in Medicare this year, according to a recent issue of Kiplinger Newsletter.

continued

Medical Economics

continued

teenage pregnancy and violence of all the world's developed countries. (According to a recent issue of *Kiplinger Newsletter*, 30% of American babies are now born out of wedlock — up from 18% in 1980. Experts are predicting this illegitimacy rate will have far-reaching effects since these children do worse in school and are more likely to be violent.)

According to HPI, treating our social problems accounts for \$225 billion of America's \$945 billion health care bill.

The chart below is a breakdown of costs directly associated with social issues.

HEALTH CARE COSTS DIRECTLY ASSOCIATED WITH SOCIAL PROBLEMS

• Alcohol abuse	\$50 billion
• Smoking	\$50 billion
• Poverty (care for illegal immigrants, delayed medical care, lack of immunizations)	\$25—\$50 billion
• Cultural attitudes (heroic measures)	\$33 billion
• Unsafe sex (AIDS, pelvic inflammatory disease)	\$19.4 billion
• Violence (homicide, assaults, rape, arson)	\$10 billion
• Drug abuse	\$6.7 billion
• Gambling	\$6 billion

Keep a cool head in face of a lawsuit

Getting sued is a highly unpleasant experience, but it doesn't have to be personally devastating if you maintain a calm and positive outlook. That's the advice offered in a recent edition of *Minnesota Physician*.

Though the case against you may be dated or frivolous, you are forced to defend it. Remember that this is what legal professionals are for. The legal world is vastly different from the medical world, so try not to be too rigid or overly-defensive. It is normal to be frightened, but acquainting yourself with the legal process you will have to go through will make it easier.

Once you have obtained legal advice that you trust and are comfortable with, try to focus your life on something else — your practice, your family, a hobby. If you let a lawsuit consume your life, you lose — no matter what the outcome in court.

When your case goes to trial, budget suffi-

cient time for work needed on the case and time for yourself. Take care of yourself so you will do your best in the trial.

Finally, remember that you can be totally in the right and still lose. You can't necessarily control that. This is why you have malpractice insurance.

Employer expectations of HMOs

Only 20% of respondents in a recent survey listed HMO accreditation by the National Committee for Quality Assurance as an important criteria for selecting an HMO. Access by employees and their dependents was listed by 72% of respondents as the most important criteria when selecting HMOs.

Only 8% listed an HMO's ability to provide HEDIS reports as an important criteria.

The survey of 196 mid-size to large companies was conducted by *National Underwriter* magazine.

Health care costs below inflation

After a decade in which health care costs exceeded the inflation rate four times over, a new study finds that health insurance premium increases have finally begun to fall below inflation, *AM Best* reports.

According to the report, employers' cost at more than 1,000 medium sized and large companies rose just 2% from 1994 to 1995, compared with an overall inflation rate of 2.8%.

The report said the widest disparity between the inflation rate and premium increases occurred in 1989, when premiums shot up 20% and the inflation rate was 5%. **IM**

Getting sued is a highly unpleasant experience, but it doesn't have to be personally devastating if you maintain a calm and positive outlook.

Practice Management

IMS physicians interested in data

Physicians and their office staff are extremely interested in learning more about the roles of data and technology in future medical practices, according to a recent survey of IMS members.

The survey, which got a 24% response rate, produced two major conclusions regarding the focus of future IMS activities:

- IMS should continue its practice management educational activities, striving to provide "cutting edge" education for members and their staff.

- IMS should undertake an exploration of appropriate roles for the IMS in the emerging areas of data and technology.

The survey results show that the quality of IMS educational programs is felt to be equal or higher than that of comparable programs.

According to the survey, 92% of IMS members are using computers in their practices and 89% are submitting insurance claims electronically. The size of the practice corre-

lates directly with their interest in data — many larger groups are already using peer comparison data. Smaller offices (under 20 physicians) said that assisting members with data should be an IMS priority.

At its November meeting, the IMS Board of Trustees reviewed the survey results in the context of the IMS strategic plan.

Medical Business Specialist graduates

Three Medical Business Specialists completed the requirements for their certificate during the fall 1995 seminar schedule. They were presented their plaques at seminars in September and October.

Lana Slagle, secretary to Dr. Carol Scott-Conner, head of the UI Department of Surgery, began the MBS program in May, 1994.

"As an academic administrative secretary at the U of I Hospitals and Clinics, I do not get the chance to work with many skills taught in

continued

AT A GLANCE

What questions are you allowed to ask of job applicants with disabilities? New Equal Employment Opportunity rules let employers ask applicants who are obviously disabled about accommodations they would need to do a job. For a free copy of the guidelines, write to: Office of Community Affairs, EEOC, 1801 L Street NW, Washington, DC 20507. To order by phone, call 800/669-3362 and ask for "ADA Enforcement Guidance: Preemployment Disability Related Questions and Medical Examinations".

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Patient satisfaction has never been more important. Your patients have become educated consumers of health care. They are aware that you are selling a service and that they are buying it. The focus of the managed care market has also turned toward patient satisfaction. With all this attention on pleasing patients, their expectations have risen.

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To help improve your patient satisfaction:

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- Avoid medical jargon. Use the patient's vocabulary level.
- Use written and audiovisual methods to communicate information.
- Give patients your undivided attention. Try not to interrupt their "story".

For further information, contact Lori Atkinson, MMIC risk management supervisor, MMIC West Des Moines office, PO Box 65790, West Des Moines, Iowa 50265, 800/798-9870 or 515/223-1482.

It's only a matter of time before you are the target of marketing by potential CHMIS networks wanting you to sign a contract. Before you do, read the important information on page 476 of this issue.

Practice Management

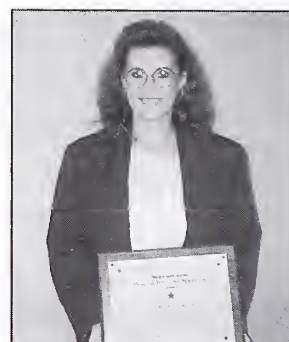
continued



Lana Slagle



Denise Schroeder



Shemain Pirmann

this program, such as coding and billing," Ms. Slagle commented. "However, the overview I received with respect to what is happening in the private medical office and in various offices of UIHC was very educational. I was able to get the big picture and an appreciation of how my job fits into the organization. I enjoyed this Iowa Medical Society program and hope it continues to expand."

Denise Schroeder, clinic manager of the Franklin Medical Center, Inc. in Hampton, began the MBS program in June, 1994. Ms. Schroeder makes the following comment about the experience: "The MBS program gave me a better understanding and knowl-

edge which has benefited me in my role as clinic manager."

Shemain Pirmann is computer supervisor for Obstetrics & Gynecology Specialists, PC in Davenport. She began the MBS program in May, 1994.

"I am pleased to say that I enjoyed being involved in the MBS program. I gained some good and helpful knowledge. I strongly recommend this program for managers and other staff members."

Congratulations to these three MBS participants. **IM**

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Newsmakers

Handbook is "comprehensive and impressive"

Dear Editor:

Thank you for permission to reproduce the "Physicians' Handbook on Domestic Abuse," provided by the Iowa Medical Society. The handbook and "Break the Silence, Begin the Cure" video will be used for our second year DO students in their psychiatry seminar on domestic violence.

For some time I have been looking for a comprehensive, educational program on domestic violence for our students. I commend the IMS and Blue Cross Blue Shield for this valuable resource. The handbook is comprehensive and impressive. The video incorporates relevant data and necessary dynamics for student training.

Please convey my sincere appreciation to all of the participants of this very fine project. — *Rebecca Monsma, MSW, Department of Behavioral Medicine and Psychiatry, University of Osteopathic Medicine and Health Sciences, Des Moines*


Awards, appointments, etc.

Dr. Alan Bollinger, Des Moines, has been appointed director of emergency medicine services at Broadlawn Medical Center. **Dr. Michael Sparacino** has been named the program director for Family Practice Residency at North Iowa Mercy Health Center in Mason City. **Dr. Kory Kazarian**, family physician, has joined the Covenant Clinic in Cedar Falls. **Dr. Greg Halbur**, family practice, has joined Midtown Medical Clinic in Sioux City. Two new clinical department heads have been appointed at the UI College of Medicine: **Dr. Evan Kligman** will direct the Department of Family Practice and **Dr. Carol Scott-Conner** will head the Department of Surgery. Dr. Kligman succeeds Dr.

Gerald Jogerst who has served as interim head of the department since June 1994. Dr. Scott-Conner succeeds Dr. Robert Soper who has served as interim head since 1992. **Dr. Scott Aigner** has joined Dubuque Urology. **Dr. Patrick Sterrett** has joined Dr. David Field in medical practice in Dubuque. **Dr. Robert Burke**, general surgeon, has retired after 36 years of practice in Jefferson. **Dr. Meredith Saunders** has joined Physicians Eye Clinic in West Des Moines. **Dr. Axel Lund** and **Dr. John Reinertson** of Marshalltown Family Medical Services have joined McFarland Clinic in providing services to the Marshalltown area. **Dr. James Collins**, Waterloo, has been appointed to represent the Federation of State Medical Boards on the Accreditation Review Committee of the Accreditation Council for Continuing Medical Education. Dr. Collins is chairman of the Iowa Board of Medical Examiners. **Dr. Arthur Devine**, urology, received the Thirlby Award as the practicing member judged to have given the best scientific presentation at the annual meeting of the North Central Section of the American Urologic Association. **Dr. John Wollner**, Cedar Rapids internist, has been named chairman of the comprehensive school health education committee of the American Cancer Society, Linn County Unit. **Dr. Donald Young**, professor in the Department of Radiology, UI College of Medicine and a member of the AMA's Council on Scientific Affairs, has been appointed chairman of the Diagnostic and Therapeutic Technology Assessment Committee of that Council. **Dr. Jerome Gleich** of Ottumwa Regional Health Center, has been awarded status as a diplomate board certified forensic examiner of the American Board of Forensic Examiners.

Deceased members

Harry Alcorn, MD, 75, ophthalmology, Clear Lake, died April 4

Lancelot Eller, MD, 87, life member, family practice, Richland Center, Wisconsin, died August 7 

AT A GLANCE

Dr. Paul Seebohm, emeritus professor at the UI College of Medicine, Iowa City, was recently honored at a dedication of a conference room named in his honor.

Mercy Hospital Medical Center, Des Moines has been recognized as a Level II Trauma Center by the American College of Surgeons Committee on Trauma. The verification makes Mercy one of fewer than 60 hospitals nationwide to receive this stamp of approval and only the second American College of Surgeons verified trauma center in Iowa.

Stark

self-referral law



STEVEN BECK, JD

Mr. Beck is chair of the firm's health law department. His practice focuses on advising physicians, hospitals and payers on health care integration and joint ventures.



DAVID GLASER, JD

Mr. Glaser is a member of the firm's health law group. The focus of his practice is health care regulation, including regulatory compliance and appeals.

The authors practice with the firm of:

Fredrikson & Byron
900 Second Avenue South
Minneapolis, MN 55402
612/347-7000

Should Iowa physicians worry about the Stark law? Probably. In September, after a nearly four-year delay, the regulations for Stark I took effect. This article discusses how the Stark I and II self-referral laws might affect your practice.

In the last few years, Congress passed two self-referral laws, commonly referred to as Stark I and II. Because Stark I involved referrals for laboratory services, the regulations do not answer all of the questions about the other designated health services covered by Stark II. Several proposals have been introduced in Congress to scale back the Stark law.

Law has broad reach

The Stark law has a very broad reach; if you haven't considered the law's impact, one of its provisions is likely being violated in your practice. The penalties for a violation are severe — up to **\$15,000 per claim** submitted to Medicare or Medicaid and exclusion from the Medicare program.

Stark is not an intent-based rule. The government does not need to prove that your medical judgment was affected by the financial arrangement. If you have any compensation arrangement that violates the law, you may be

fined \$15,000 for each claim you submit to Medicaid or Medicare. The law is very complex and this article focuses on six of the most commonly-asked Stark questions.

1

WHAT DOES STARK PROHIBIT?

Stark prohibits a physician from "referring" a Medicare or Medicaid patient to any clinic or entity for one of 11 "designated health services" if the physician has ownership interest in the entity (through equity or debt) or receives any compensation for it. Compensation is defined quite broadly. If a physician receives cash or services from an entity, it is considered compensation.

The government does not need to prove your medical judgment was affected by the financial arrangement.

2

WHAT IS A "REFERRAL"?

The law defines referral quite broadly, including many situations that most physicians would not consider a referral. With a few exceptions, the law says that whenever a physician develops a plan of care for a service, the

physician has made a referral. As a result, if you recommend physical therapy to a patient you have made a referral for a designated service, even if you do not tell the patient where to receive care. If money changes hands between you and the therapist selected by the patient—either through a lease or any other arrangement—Stark is implicated.

3

WHAT ARE DESIGNATED HEALTH SERVICES?

The following services are considered “designated health services”:

- clinical laboratory services
- physical therapy
- occupational therapy
- radiology or other diagnostic services
- radiation therapy services
- durable medical equipment
- parenteral and enteral nutrients
- equipment and supplies
- prosthetics
- orthotics and prosthetic devices
- home health services
- outpatient prescription drugs
- inpatient /outpatient hospital services

The law does not further define these terms and, in some cases, it is difficult to discern the legislators’ intent. For example, “outpatient prescription drugs” would appear to cover only prescriptions to hospital patients. However, until final regulations governing Stark II are published or the law is repealed, these terms will remain ambiguous.

Remember, only Stark I regulations have been issued at this time. These cover clinical laboratory services.

4

WHAT ARE THE EXCEPTIONS?

Exceptions to the law fall into three broad categories. Some apply to compensation arrangements, some apply to ownership or investment interests and some apply to both.

Ownership and compensation arrangements

The most powerful exception applies to most in-office ancillary services other than DME or parenteral and enteral nutrition. In-office ancillary services must be provided within a group practice and directly supervised by a physician. (Direct supervision requires a physician to be able to reach the area within about 30 seconds.)

The key term is “group practice”. To qualify, no portion of a group’s compensation system may be “based on the volume or value of referrals”. While it is possible to include a physician’s personal production in a clinic compensation formula, Stark prohibits clinics from crediting physicians with the value of referrals for ancillary services.

Any practice that has a physician who provides services to another practice must be particularly careful. Whenever a practice bills for services rendered by a physician, that physician is considered part of the group practice.

The regulations require that 75% of the

The law prohibits clinics from crediting physicians with the value of referrals for ancillary services.

Regulations require that 75% of the professional services provided by members of the group must be billed by the group.

professional services provided by members of the group must be billed by the group. Small groups that bill for the services of a physician who spends time at another practice may have difficulty meeting this standard.

For example, assume that two members of a practice spend 100% of their time at a clinic, while the third physician spends 10% and the remainder of his practice is elsewhere. Using the formula in the regulations, only 70% of the aggregate services provided by the physicians are provided through the group. As a result they would not qualify as a "group practice".

Ownership interest exceptions

Providers who practice in a rural area are covered by an exception which allows them to have an ownership interest in a designated health service. To qualify, 75% of the clinic's patients must live outside of an urban area. In Iowa, the following counties are

considered urban: Black Hawk, Dubuque, Woodbury, Pottawattamie, Linn, Scott, Dallas, Polk, Warren and Johnson. Of course, a rural practice must still design its compensation system to comply with Stark. Lab and other ancillary services must be excluded from the compensation formula.

Another exception allows ownership in large, publicly traded companies. The company must have total assets of at least \$75 million.

The third exception allows a physician to own part of a hospital if the physician provides services at the hospital and the ownership interest is in the entire hospital, not merely a subdivision.

Exceptions to compensation arrangements

A lease of office space or equipment qualifies for an exception if the lease is written, runs for one year and contains a "reasonable" rental payment set in advance in some manner that does not take into account the value or volume of any referrals or other business generated between the parties. In addition, the space or equipment must be used exclusively by the lessee during the relevant period.

As a result, it is improper to lease a room or equipment on an "as needed" basis. The lease must define specific hours of use.

A bona fide employment relationship qualifies for an exception if the services are identified in a contract and payment is consistent with fair market value and does

DESIGNATED HEALTH SERVICES UNDER STARK LAW:

- clinical laboratory services
- physical therapy
- occupational therapy
- radiology or other diagnostic services
- radiation therapy
- durable medical equipment
- parenteral and enteral nutrients
- equipment and supplies
- prosthetics
- orthotics and prosthetic devices
- home health services
- outpatient prescription drugs
- inpatient and outpatient hospital service

not take into account the value or volume of referrals (including referrals for designated services within a group practice). The agreement must be considered commercially reasonable when viewed as if no referral relationship existed.

The personal service exception permits an entity to contract with a physician. The contract must be for at least one year, describe all of the services to be performed and serve a legitimate business purpose. Compensation must be set in advance and may not take into account the value or volume of referrals.

5

DOES STARK AFFECT ME IF I SELL MY PRACTICE?

Yes. If you will be referring patients for designated health services to the entity which purposes your practice, the sale of the practice must be paid in one lump sum.

Also, any compensation paid to you will have to satisfy one of the exceptions under Stark.

6

WHAT IS THE REPORTING REQUIREMENT UNDER STARK?

There are two reporting requirements in the law:

- Every group practice must complete a form designed by HCFA. The regulations state that the form must be completed by December 12, 1995. However, since the form

has not yet been designed, some HCFA officials have indicated the deadline will be extended.

This attestation is significant because the government will argue that any group which completes the form but fails to comply with every element of the group practice definition has been submitting false claims.

Under the False Claims Act, both the federal government and private citizens may have the right to file suit against providers who have filed an incorrect attestation. In some circumstances the private citizen may be eligible to claim up to 30% of any recovery.

Since the False Claims Act may result in penalties of \$5,000—\$10,000 per claim, it provides a strong incentive for both federal regulators and private citizens to actively seek violators of the law.

- All entities that provide designated health services must provide information about every physician with a financial relationship to the entity. Medicare carriers will develop this form and send it to providers in the near future. Failing to complete the form can result in a fine of \$10,000 per day.

Stark is a complicated law. Unless it is entirely repealed, all providers must consider whether they are in complete compliance. If you have questions about Stark law and your own practice, contact an attorney who specializes in health care issues. **IM**

Unless Stark is entirely repealed, all providers must consider whether they are in compliance.

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Attention IMS Emeritus and Life Members

Recently you received a letter regarding *Iowa Medicine* magazine. A postcard was enclosed which must be returned no later than **December 20** if you wish to continue receiving the journal. If you haven't received the letter and postcard and want to remain on our mailing list, please give us a call at 800/747-3070 or 515/223-1401 (ask for Jane Nieland or Bev Corron).



Emergency Medicine Opportunity

North Iowa Mercy Health Center (NIMHC), Mason City, Iowa, is a private, not-for-profit, 350-bed medical center that services a 14+ county region in north central Iowa. For most of a century, NIMHC has combined the most advanced technology with compassionate care to provide our region with quality medical services.

We are seeking a BC/BP primary care physician with emergency medicine experience or an emergency trained physician for a full-time position in our facility. We invite you to become a part of our 4-member team in a modern ED with 23,000 annual visits and weekend double coverage. This position offers competitive compensation and an exceptional benefit package.

Mason City represents the best of the Midwest. It has quiet, tree-lined streets in modern neighborhoods and radiates that storybook "hometown" feeling. An incomparable lifestyle can be derived from the matchless public and parochial school system, a strong and growing economic base and the availability of ample recreational activities.

We would welcome the chance to discuss how this opportunity can fulfill both your professional and personal needs. For more information, please contact:

Laura Weis, Representative
North Iowa Mercy Health Center • c/o Mercy Health Services
4500 Westown Parkway, Suite 250 • West Des Moines, Iowa 50266
515/224-3260; 515/224-3546 (fax)

The Journal

of the Iowa Medical Society

Prostate cancer management in older patients

● WILLIAM SEE, MD

Prostate cancer is the most commonly diagnosed malignancy among Iowa men. A recent report by the National Cancer Institute Surveillance Epidemiology and End Result Program (SEER) suggests that in Iowa, as well as other sites across the country, the use of radical prostatectomy as definitive therapy for this malignancy has increased dramatically in the last decade.¹ Furthermore, data from this study suggests that the use of radical prostatectomy has seen its greatest increase in patients 70 years and older. From 1991 to 1994 the proportion of men with prostate cancer 70 years of age and older who received radical prostatectomy increased from 4% to 16.9%.

The controversy regarding the optimal management of prostate cancer, both in general and for elderly patients in particular, remains heated.² Indeed, conflicting literature can be used to support almost any approach to the treatment of this enigmatic neoplasm.

In an effort to define the patterns of care of prostate cancer in the state of Iowa, particularly as they relate to age at the time of treatment, a multidisciplinary group was formed to study patterns of care. The following report summarizes the methods, findings and conclusions of that group.

Materials and methods

At the prompting of Iowa's state health care quality assurance group (Iowa Foundation for Medical Care, IFMC), an interdisciplinary group of health care professionals, including urologists and medical and radiation oncologists, was formed to consider prostate cancer care delivery issues. After a review of preliminary data, the group focused

on variations in care delivery for prostate cancer patients as a function of age.

Data collected from every Iowa hospital by the staff of IFMC included institution-specific numbers of radical prostatectomies performed per year and the number performed in patients 75 years of age and older. Subsequently, six institutions were selected for more detailed review. Of these six institutions, five were in the top five institutions with respect to those performing the greatest number of radical prostatectomies per year.

A chart review was performed on the 25 oldest patients undergoing radical retropubic prostatectomy in the last year at each of the six institutions. Patient comorbidity was estimated by the incidence of concomitant disease processes, including coronary artery disease, chronic pulmonary disease, dementia, diabetes mellitus, deep vein thrombosis, renal insufficiency or cerebral vascular disease. An additional estimate of overall patient health was obtained from the anesthesia record documenting anesthesia risk class. Treatment outcomes were estimated based upon acute surgical morbidity and pathologic stage of the patient following the radical prostatectomy. Outcomes among the six institutions were then compared.

Results

The proportion of cases 75 years of age or older showed no correlation between number of prostatectomies performed, institution size or size of the city population served. Absolute percentages among the 13 institutions varied from 0% to 20% of the total number of prostatectomies performed.

The findings from the detailed subset analysis of six institutions are summarized in

The IMS Education Fund has designated this article as the Henry Albert Scientific Presentation Award for December 1995.

WILLIAM SEE, MD

Dr. See is associated with the Department of Urology, UI College of Medicine, Iowa City and the Iowa Prostate Cancer Cooperative Project.

Other contributing authors: Robert Dreicer, MD; Dennis Boatman, MD; David Hussey, MD; Leo Millemann, MD; Paul Rohlf, MD; Steven Rosenberg, MD; Markham Anderson, MD; A. Curtis Hass, MD; Andrea McGuire, MD; Roscoe Morton, MD; Pat Ouwerson, RN; Merle Wilson, EdD; Marilyn Schulte, RN and Timothy Kresowik, MD.

Prostate cancer management in older patients

continued

Table 1. Institutional caseload-percentages for men 75 years of age and older varied from 2.3% to 20%. Age distributions for the oldest 25 cases among the six hospitals ranged from 4% to 100% age 75 or older. However, rates of presurgical comorbidity, acute postsurgical morbidity and final pathologic stage among the six institutions were comparable.

TABLE 1
RESULTS OF ANALYSIS OF THE 25 OLDEST
PATIENTS UNDERGOING RADICAL
PROSTATECTOMY AT SIX IOWA HOSPITALS

	Facility					
	1	2	3	4	5	6
# of radical prostatectomies performed	81	24	70	106	150	42
% >75 years	2.5	20.8	4.3	12.3	14.0	4.8
% of oldest 25 patients aged >75	4	20	12	52	100	16
% of oldest 25 patients w/>1 comorbid condition	8	0	0	8	8	28
total # comorbid condition	12	11	8	13	11	20
mean ASA class	2.15	1.92	2.17	2.25	2.29	2.00
% postop complications	4	4	8	0	4	4
% stage C	24	28	20	28	12	36

Discussion

The management of carcinoma of the prostate is an area of current controversy. Despite an abundance of opinion, there is insufficient data to definitively support any conclusion regarding who should be treated, by what modality and when. Given the wide variation in the available literature, virtually any approach can be justified if literature is selectively interpreted. The current statewide review of prostate cancer patterns of care was undertaken in an effort to determine whether there were wide variations in patterns of care within Iowa. Given the recently documented dramatic increase in the use of radical prostatectomy as curative therapy and particularly its growth as primary therapy among men 70 years of age and older, the group decided to focus the efforts of the current review on patterns of care as a function of age. While the

group recognized that many other issues merit consideration, the age-adjusted use of radical prostatectomy seemed timely and significant.

Despite variations in the age distribution of men treated by radical prostatectomy at various institutions, presurgical comorbidity and acute postoperative morbidity among the oldest group of patients at each institution appeared quite comparable. Chronological age appears to be but one of multiple factors considered in determining candidacy. The overall low rate of postoperative complications and the absence of operative mortality among these elderly patients speaks to the surgical judgment and skill of physicians performing radical prostatectomies in Iowa. Finally, comparable postoperative pathologic states suggest that prostate cancer in select men age 75 and older is as potentially curable by radical prostatectomy as that of men in younger age groups.

Findings from this limited study suggest that, in Iowa, relatively uniform criteria are being used to select patients for radical prostatectomy, irrespective of patient age. Careful patient selection, both in terms of the ability to tolerate the operation and the potential of the individual patient to see survival benefit from the procedure, remains the cornerstone of good patient care.

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1. Harlan, L, *et al*: Geographic, age, and racial variation in the treatment of local/regional carcinoma of the prostate. *J Clin Oncol* 1995;13:93-100.
2. See, WA: Prostate cancer therapy: a recipe for confusion. *Iowa Med* 1994;255-58.

A gift to your grandchildren

Consider an apple core. Compartments of little brown seeds provide a marvel of nature; one seed may mature to a fruit-bearing tree. Ponder the bushels of delicious apples the tree will provide year after year. All from one small seed.

There are seeds we can plant for our children and grandchildren that will give them a more satisfying life. One attribute we can promote is one that is sadly lacking in present day education. The youth of today lack the ability to transform words into thought processes, both in spoken language and especially in writing. Educators aver that there is too little time in the curricula to teach writing. Nancy Cole, president of the Educational Testing Service, the organization that administers SAT and other tests, says teachers do not have enough time to teach writing. Writing is no longer considered a school subject. She adds that it is too time consuming to grade written papers.

It appears it is up to the parents to stimulate children to become better writers. There are many things we can do to help. Reading and writing are closely intertwined; consequently, it is incumbent upon us to encourage reading as well. That can become a simple task. Write notes and letters to the children, hopefully encouraging them to answer in writing. It has become too easy to communicate orally.

The October 1995 issue of *Better Homes and Gardens* has an excellent short article

entitled "The Write Stuff". The author discusses how to encourage people to write more. Some of the methods discussed include such simple tasks as helping to compose the grocery list to more complicated adventures in learning such as writing a brief review of something learned from reading a book or even an encyclopedia. Another area is encouraging the child to keep a journal, or writing bits of family history gleaned from interviews with family members.

As part of your holiday giving, write letters to the children and the grandchildren instead of relying upon AT&T, MCI or Sprint. For the younger ones, printing the letter would be more appropriate. To encourage handwriting, the typewriter should be discouraged. The

**Write letters
to the
grandchildren
instead of
relying upon
AT&T.**

children's written responses will be valuable additions to the refrigerator door and can be kept for future enjoyment. That future enjoyment will be fun for the child as well as comparisons can be made of the progress of the writing skills.

There is no question the child will profit from your writing, and your enjoyment of their letters and notes will be an immeasurable gift of love from them. **IM**



MARION ALBERTS, MD

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Learning from our legal colleagues

Note: This is the final article in a three-part series on interdisciplinary CME.

Being the student of a mentor within the same medical discipline, or learning from a colleague in another health care profession are accepted educational modes among physicians. Learning from persons less directly engaged in health care may be another matter for doctors. Some physicians question the need or value of such learning.

Yet the practice of medicine exposes physicians to a broad spectrum of societal issues and values, each with a learned constituency. Contemporary health care is hardly conceivable without interactions with public officials, health care financing managers, the clergy, attorneys and others.

There may be no group about which physicians have more ambivalent convictions than attorneys. In the collective mind of the medical profession lawyers are either leading the assault against reason and common sense in the care of patients, or they are the last bastion of defense against the insatiable public demand for error-free medical care.

Attorneys, as heterogeneous a professional group as physicians, represent a spectrum of influences on medical practice and have had a profound impact on the delivery of health care. That impact is not necessarily onerous. A convincing case might be developed that demonstrates how attorneys and the law

have enlightened the profession.

Two examples may suffice for illustration. The first is the development of the practice of informed consent. Most consumers (or their advocates) would characterize informed consent as a means to protect patients from unwarranted risk without adequate benefit. Physicians might well view the practice of informed consent as the protection of the physician from unwarranted expectation without understanding of risk. Informed consent should serve both functions. Our attorney colleagues have protected each party in the health care transaction through informed consent.

The second illustration may be more controversial. Attorneys assist physicians in maintaining the quality of practice by litigating cases which question medical competence. While physicians may rail against the abuses inherent in many such procedures, there is no doubt that some persons have been harmed by their physicians' acts or negligence. We strive for preventive

peer review, but the potential of legal redress frames the issue. As physicians and consumers, we would not want a system without such protection.

Learning from attorneys may not have been an expectation of physicians when they embarked on their careers, but we should be open to the unanticipated. **IM**



RICHARD NELSON, MD

There may be no group about which physicians have more ambivalent convictions than attorneys.

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Mason City 50401
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Sioux City 51101
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Ida Grove 51445
712/364-3311

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Orange City 51041
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Fort Dodge 50501
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Marshall C. Greiman, MD
Steven R. Herwig, DO
Thomas O. Paulson, MD
Mark K. Zlab, MD
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